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HOPE.

Have hope. Though clouds environ now,
And gladness hides her face in scorn,
Put thou the shadow from thy brow;
No night but hath its morn.

—Schiller.

SURGICAL PATHOLOGY

AND

MORBID ANATOMY

STUDENT'S GUIDE SERIES

SURGICAL PATHOLOGY

AND

MORBID ANATOMY

BY

ANTHONY A. BOWLBY, F.R.C.S.

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SURGEON TO THE ALEXANDRA HOSPITAL FOR HIP DISEASE

WITH 135 ILLUSTRATIONS

PHILADELPHIA
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1887

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87

TO

THE STUDENTS

OF

ST. BARTHOLOMEW'S HOSPITAL

THIS WORK IS

Dedicated

BY THEIR SINCERE FRIEND

THE AUTHOR

PREFACE.

My object in writing the following pages has been to describe as simply as possible the various Pathological processes which are of interest to the student of surgery.

With this intention, I have, throughout this book, dealt first with diseases as they are met with during life, and have then described their natural courses and terminations, and the morbid appearances presented by the structures involved.

I have endeavoured, as far as possible, to express the current views of pathologists, especially those of the English school; but have not hesitated to make use of my own observations and of the abundant pathological material supplied by the museum and post-mortem room of St. Bartholomew's Hospital. The space at my disposal and the nature of the work have not permitted many references to the authors consulted, and the few that are made relate chiefly to papers whose contents are not yet generally included in the textbooks.

7-1104

The drawings with which the book is illustrated are original, and have been made by Mr. T. Godart from specimens now in the museum of St. Bartholomew's Hospital, with the exception of five which are from specimens in that of St. Thomas's Hospital. I believe that all of them are faithful copies of the morbid appearances they represent. The blocks for printing have been prepared by the "Typo-Etching Company."

My best thanks are due to my friends Mr. James Berry, Mr. D'Arcy Power, and Mr. Edgar Willett for much valuable advice, and for assistance in revising the proof-sheets.

43 Queen Anne Street,
Sept. 1887.

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SURGICAL PATHOLOGY.

CHAPTER I.

HYPERTROPHY AND ATROPHY.

HYPERTROPHY.

HYPERTROPHY means increase in size, and is a term usually limited to increases which are evidently abnormal in their extent.

The increase in size of any tissue may be the result of an increase in either the number or the size of its constituent elements, the former variety being called numerical, the latter simple; they are frequently coincident. In **true** hypertrophy the various constituent parts of the organ or tissue affected are all equally overgrown; in **false** hypertrophy, although the organ or tissue is larger than natural, its overgrowth is due to an increase of one or more of its constituent elements, to the exclusion of the others. The term hypertrophy is indeed misapplied in such instances, for, if it be employed to imply increase in size, it is evident that it should not be used where there is, in addition, alteration in structure.

There are two chief causes of hypertrophy: first, **increased use**; second, **increased blood-supply.** With regard to the former, it may be said that increase of function is always accompanied by increase

in growth, so long as the work required be not excessive. True physiological hypertrophies, the result of increased use, are best seen in the muscles of a healthy person when called upon for greater exertions than are usual, or in the uterus during pregnancy. From a pathological point of view, they are most often the result of disease of some other tissue or organ, whose impaired functions are supplemented by increased functional activity in the healthy parts. Examples of such **secondary** or compensatory hypertrophies are common, and good instances are supplied in the hypertrophy of one kidney when the other is diseased, the increase in size of the fibula when the tibia is congenitally absent, and the thickening of the muscular walls of the heart in cases of valvular disease, or of those of the bladder in obstructions caused by enlarged prostate or stricture of the urethra.

The hypertrophy which results from increased blood-supply may occur in tissues which are otherwise normal, but is most often seen in connection with irritative or inflammatory lesions. Hunter's experiment of transplanting the spur of a cock on to its comb affords an excellent example of the former, for the spur, nourished by a greatly increased vascular supply, grew to many times its original size. In the same way, the hair in the neighbourhood of a chronic ulcer, or an inflamed joint, though itself healthy, often grows longer and becomes more thick on account of the vascularity of the skin in the neighbourhood of the inflamed area.

More often, however, the overgrowth which is dependent on increased blood-supply is the result of some abnormal condition of the tissue itself. Thus, the irritation of a badly fitting boot, or the intermittent pressure of a tool on the skin of the palm, often results in the thickening of both the derma and epidermis, and the effects of intermittent pressure on a bone is similarly shown in the formation of new

bone from the periosteum. Hypertrophies such as these are called **irritative.** It is worth while to mention yet one other instance, for the results are sometimes very striking. In cases of chronic inflammation kept up by any cause in the neighbourhood of the epiphysis of a growing bone, the increased supply of blood to the developing tissue is followed by a corresponding increase in growth, and thus the limb on the diseased side may become longer than its fellow. In the tibia such overgrowth is accompanied by curvature, for, being fixed to the fibula, it is unable to grow in length more rapidly than the latter bone, unless at the same time it yields to the resistance offered by the fibula.

In some cases parts become hypertrophied without any apparent cause, and a toe or a finger may continue to grow after the growth of its fellows has ceased till it becomes more than twice the normal size. In other cases whole limbs become hypertrophied, but we know no more what is the cause of this overgrowth than we know why the growth of any one part of the body ceases when its natural development has been attained.

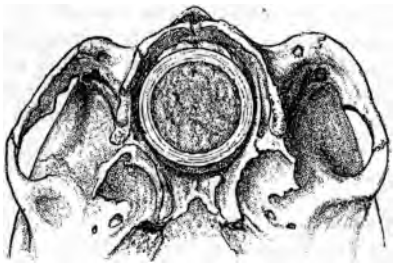
ATROPHY.

Atrophy means diminution in size without alteration in structure, and, if the term be strictly used, pure atrophies will be found to be of rare occurrence.

Causes.—The most important causes of atrophy are, first, **deficient blood-supply**; second, **deficient use.** The deficient blood-supply is frequently itself the result of some morbid process, and is often caused by pressure. As already mentioned, intermittent pressure, by causing irritation, induces hypertrophy; but **continuous pressure,** on the other hand, induces atrophy. No better instance of this can be desired than the atrophy of all the tissues which is often caused by the pressure of an aneurysm, for not only are the soft structures destroyed, but bones and

cartilages may be completely removed. Thus, in the case of an aortic aneurysm, the ribs or the sternum may be either simply eroded or entirely absorbed in their whole thickness, and the bodies of the vertebræ may be similarly affected; this absorption or atrophy results from the obliteration of the blood-vessels by the pressure of the aneurysmal sac. The specimen depicted in Fig. 1 shows the complete absorption of the whole of the hard palate caused by the constant wearing of a cork inserted to plug an aperture which communicated with the nostrils. The patient was an old woman, and, as the hole constantly grew larger, it became necessary to increase the size of the cork, and finally to add to its circumference by wrapping it with strips of tape.

FIG. 1.

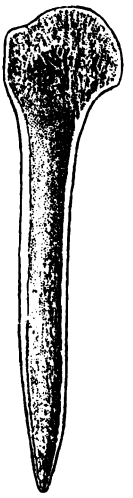


Part of the Base of a Skull, showing a cork surrounded by several layers of tape plugging an aperture in the hard palate.

The atrophy which results from deficient use or diminished functional activity is well seen in the condition of a limb in which one of the joints has long been diseased. In such, the soft tissues as a whole are diminished in bulk, and muscles, vessels, and nerves all share in the general atrophy. The bones do not escape; they become hollowed out from within, and reduced to mere shells—eccentric atrophy—whilst at

the same time their transverse diameter also lessens—concentric atrophy—and thus both eccentric and concentric atrophy go hand in hand. Similar wasting may be seen in the tissues that form an amputation stump, the bone in which is often atrophied to such an extent that it measures less than a third of its normal circumference (Fig. 2). The diminution of the optic nerve after removal of the eyeball, and of the renal artery when the corresponding kidney has been destroyed, afford other good examples of the same process.

FIG. 2.



The Upper Half of a Humerus from a Stump. The bone is both diminished in its circumference and hollowed out from within, the compact tissue being greatly diminished in thickness.

Many more varieties of atrophy might be mentioned, but not only are they more suitably discussed in works on general pathology—they are also for the most part physiological rather than pathological. Thus, the atrophy of the thymus gland in childhood and of the breasts after the cessation of menstruation cannot justly be considered as in any way abnormal, and therefore find no place in works on pathology, except for purposes of comparison or illustration. Another cause of atrophy which is commonly mentioned is excessive use, but it is questionable whether this ever induces an atrophy which can be considered pathological.

The other forms of atrophy which are accompanied by fatty changes in the affected tissues, and which are more common than the pure atrophies, will be considered in the ensuing chapter on "Degeneration."

CHAPTER II.

DEGENERATION.

THE term **degeneration** is used to imply an alteration in structure whereby the organ or tissue affected is rendered less able to perform its normal functions, the tissue elements themselves being replaced by material of inferior quality.

FATTY DEGENERATION.

The most common form of degeneration is that named **fatty.** In it the cells and fibres are replaced by fatty granules, and the whole texture of an organ may by a continuance of this process be transformed into fatty matter. Whatever may be the special cause at work in any individual case, all fatty degeneration is caused by a **deficiency in the supply of arterial blood,** and this may be induced in various ways. Thus, an organ by becoming hypertrophied may outgrow its blood-supply—a condition which is well exemplified in cases of heart disease and of obstruction to the outflow of urine. The heart in one case, the bladder in the other, become hypertrophied to meet the increased work thrown upon them, and so long as the vascular supply increases in just proportion all goes well. But the day comes when the tissue outgrows its blood-supply, and then fatty degeneration ensues, the hypertrophied organ becoming dilated, and soon failing to expel its contents. It will thus be seen that hypertrophy and fatty

degeneration may co-exist in the same organ. And what is true of hypertrophy applies also to new growths. Many tumours outgrow their vascular supply, and consequently degenerate in their oldest and most central parts. Thus, in scirrhous carcinomata it is common to find fatty degeneration of the epithelial cells, and in sarcomatous growths many of the cells become filled with granules of oily material. So also with inflammatory products. In all inflammations there is a tendency to fatty change in the exuded leucocytes, and the more chronic the inflammation and the more unhealthy the patient the more noticeable is this condition. It is always best marked in strumous or tubercular inflammation, and is well exemplified by the fatty mass of disintegrated cells which fills a caseous lymphatic gland, or the pulpy synovial membrane seen in strumous joints. Again, in inflammations of arteries, whose intima, it must be remembered, is nourished by osmosis, the exudation cells are peculiarly liable to degenerate and form the so-called atheromatous abscesses and ulcers met with in chronic arteritis. Thus, whether the increase in size in a tissue be due to hypertrophy, to new growth, or to inflammatory exudation, unless the blood-supply increase in proportion to the growth, fatty degeneration will ensue.

But whilst, on the one hand, fatty degeneration may be caused by overgrowth of the tissue to be nourished, on the other it may result from cutting off of the normal blood-supply. Here, again, the heart affords an excellent example, for, when its coronary arteries are atheromatous and its muscle imperfectly supplied with blood, fatty degeneration of the walls of the ventricles commonly results, and may lead to the death of the patient either by failure of the heart's action or by rupture of the ventricle itself. In the brain also, the result of disease of the vessels is fatty degeneration and so-called "softening," a condition which is commonly met with in old people. Con-

sidering that atrophy, as we have already seen, is due to the same cause as fatty degeneration, namely, deficient arterial supply, we should rather expect to meet the two processes occurring together; and such indeed is the case. The atrophy of the tissues in old age is not a simple atrophy, but is almost always accompanied by fatty degeneration, and both are probably to a great extent dependent upon the atheroma of the vessels which is common in old people. Again, in the atrophy which results from disuse there is frequently also fatty change, and the wasting of the glandular tissues in old age, and of the muscles as well as of the bones in useless limbs, is almost always accompanied by degeneration.

If a tissue in a state of fatty degeneration be examined microscopically, its cells and fibres will be seen infiltrated with fatty granules and nuclei, and, in cases of long standing, plates of cholesterine and crystals of stearic acid may be found. If sections are stained in osmic acid, the fatty particles are turned black, whilst if they are exposed to the action of ether they are rapidly dissolved.

MUCOID DEGENERATION.

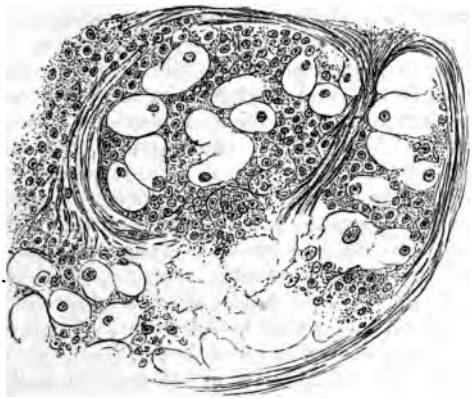
Mucoid degeneration occurring as a pathological process, has its physiological type in the formation of mucus by the glands of the mucous membranes. In these the protoplasm of the cells is constantly undergoing metamorphosis into a semi-transparent substance, which distends the cell to bursting, and finally escapes from within it. The epithelia of diseased tissues or of new growths may secrete a like material, and in other cases the ground substance between the cells undergoes similar degenerative change. Thus, in the sarcomata, chondromata, and myxomata it is common to find portions of the new growth quite soft and gelatinous, and a microscopical examination shows the cell-processes interlacing with each other in a

mass of homogeneous, mucoid matter which represents the degenerate matrix.

COLLOID DEGENERATION.

Colloid degeneration is closely allied to mucoid, the colloid substance being distinguishable only by the fact that, unlike mucus, it is not coagulated by the addition of acetic acid, and is not rendered opaque by the addition of alcohol. Colloid degeneration finds its physiological type in the formation of colloid matter by the thyroid gland, where it is produced by the epithelial cells in the same way as is mucus in the mucous glands. Colloid material is of rare occurrence as a pathological product, but is met with in the cells of carcinomata of the stomach, mesentery, and intestines, as well as in new growths of the thyroid and ovary, and more rarely in cancers of the breast (Fig. 3). Entangled

FIG. 3.



Section of a Carcinoma of the Breast. Many of the cells are distended with colloid matter, and in the lower part of the section is an irregular cavity caused by the bursting of some such cells.

in, and filling the alveoli of a carcinoma, it gives the appearance of a honeycomb filled with semi-translucent gelatinous matter, and is not easily mistaken for anything else. The occurrence of mucoid or colloid degeneration in new growths in no way affects their malignancy.

CALCAREOUS DEGENERATION.

Calcareous degeneration is a process by which a tissue becomes impregnated with various salts, the most common of which are phosphate and carbonate of lime, together with a small quantity of magnesium compounds. The deposit of such material in a growing bone is a normal process, but the cause of calcareous degeneration is not clearly understood. It is, however, a well-ascertained fact that impaired nutrition, or even death, of a tissue always precedes its calcification, and it is supposed by some authors that special forms of albumin are produced which possess special affinities for lime salts. Calcareous degeneration may occur in any part of the body, but is especially liable to affect the arteries in aged people, as well as the cartilages of the ribs, larynx, and trachea. It is also of common occurrence in the products of previous pathological processes. Thus, fatty and cartilaginous tumours frequently calcify in parts, as do also some sarcomata and fibrous tumours. The products of past inflammations are favourite sites of calcification, and good examples are supplied by caseous lymphatic glands and the cell exudation of chronic arteritis. The clots in blood-vessels also are liable, after the lapse of many years, to become calcified, and form in the veins the so-called vein stones or phlebolithes.

Microscopic examination of a tissue in an early stage of calcareous degeneration shows small shining granules deposited in the cells and matrix—where such can be distinguished—and occasionally arranged in concentric layers forming "chalky concretions." The addition

of a drop or two of hydrochloric acid causes a rapid disappearance of the calcareous matter.

AMYLOID, ALBUMINOID, OR LARDACEOUS DEGENERATION.

In this form of degeneration the tissues are impregnated with an albuminous material which in part takes the place of the diseased structure, and in part is added to it as an infiltration. The organs most commonly affected are the liver, spleen, kidneys, and intestines. The solid viscera are, in advanced cases, much increased in size, and are unduly firm to the touch. On section, they are paler than natural, homogeneous, and waxy. When portions only of the organ are implicated, the amyloid patches appear as rounded semi-translucent spherules, looking like grains of boiled sago. This appearance is most marked in the spleen, and has given rise to the term of "sago spleen." If iodine be poured over the surface of a diseased organ, the amyloid material is stained a dark red-brown or mahogany colour.

Microscopical examination shows that the amyloid substance is first deposited in the walls of the small blood-vessels, especially in their sub-endothelial cellular tissue. This readily accounts for the patchy distribution of the substance in the affected viscera, the Malpighian bodies in the kidneys and spleen being the seat of the earliest deposit, whilst the arteries which run at right angles to the long axis of the intestine, and the blood-vessels which run parallel to the renal tubules, appear as dark-brown streaks when the part is stained with iodine. The amyloid substance is not stained by logwood or carmine, and in sections prepared with these reagents appears as a homogeneous mass hiding the normal structure. In sections stained with methyl-violet, however, the amyloid matter takes on a bright ruby-red tint, whilst the healthy tissues are stained a deep blue.

The effects of amyloid disease of the viscera are very

serious, for, on account of the early implication of the blood-vessels, the nutrition of the part is much interfered with, and, later on, as the glandular elements become affected, the functions of the organ are further impaired. Advanced amyloid disease is thus frequently fatal.

By far the commonest **cause** of amyloid disease is **chronic suppuration**; it is, however, also met with in syphilis, both congenital and acquired. Cases of strumous caries and of diseased joints are very frequently fatal from this cause, but the affection is not commonly seen until the suppuration has been in progress for some months, nor unless the discharge of pus is considerable. If the cause of the suppuration be removed—*e.g.*, if the affected limb be amputated—before the disease has progressed too far, it is quite possible for recovery to result, and for the diseased viscera to gradually resume their natural size and functions. Thus, albumen may disappear from the urine, and an enlarged liver may gradually recede under the cover of the ribs after an amputation performed for long-continued disease of a joint.

The exact manner in which suppuration causes the deposit of amyloid material is not known, but various theories have been propounded. The best known of these is that of Dr. Dickinson, who has suggested that the drain on the salts of the blood caused by the long-continued secretion of pus results in the deposit of de-alkalized fibrin. It must, however, be remembered that this explanation does not hold good for those cases in which the disease occurs in the subjects of congenital syphilis, and in the absence of all suppuration.

CHAPTER III.

MICRO-ORGANISMS IN THEIR RELATION TO PATHOLOGICAL PROCESSES.

THE parasites which are found in connection with the diseases of man are many and various, but it is with only one variety of them that we are at present concerned, namely, the **bacteria** or **schizo-mycetes.** These are vegetable organisms belonging to the class of fungi, and are all of them extremely minute, many being visible only by the aid of the highest powers of the microscope. They consist of protoplasm which presents no definite structure, but is probably enclosed in a cell-membrane, and stains readily with anilin dyes. Chemical analysis shows that this protoplasm contains hydrogen, nitrogen, oxygen, carbon, phosphorus, sulphur, magnesium, calcium, and potassium.

All the schizo-mycetes multiply by fission, but some in addition reproduce themselves by spore-formation. They have been subdivided according to their shape and size into the following genera:—(*a*) micrococci, (*b*) bacteria, (*c*) bacilli, (*d*) vibrios, (*e*) spirilla.

Micrococci are round or oval organisms which grow by fission, and occur singly on in pairs, as well as in chains, and in colonies or "zoogloea masses," which consist of numbers of micrococci held together by some material of a gummy nature.

Bacteria are oval or rod-shaped organisms with rounded extremities, whose length does not exceed twice their breadth. They multiply by fission.

Bacilli are rod-shaped organisms, whose length exceeds twice their breadth, whilst in many varieties

the disproportion is much greater. Bacilli multiply by fission, but many of them, in addition, reproduce themselves by spore-formation.

Vibrios are to be regarded as bacilli which are curved instead of straight.

Spirilla are organisms of a spiral or corkscrew shape, the twist being round the longitudinal axis.

All these varieties of organisms have much in common, and all, when placed under favourable conditions, act as **ferments**, and produce certain changes in the chemical composition of the material in which they live, changes which are probably produced in one of the following ways:—

First, when living under conditions favourable for their development, the micro-organisms take from the material which surrounds them certain matters which they require for food, and by so doing split up numerous compound bodies, taking oxygen from one, carbon from another, &c. The matter which they thus take up undergoes certain chemical changes in the organisms, and the products are excreted into the liquid in which the latter live; *e.g.*, the growth of the yeast-plant in a saccharine solution produces alcohol.

Second, many bacteria produce in the above manner certain chemical substances which themselves also act as ferments and cause changes in the fluid or tissues in which they live, just as do the micro-organisms. Numerous good examples of unorganized ferments, the result of the action of cells, are to be found in the human body, and may be compared with similar ferments caused by the action of micro-organisms. Such are pepsin, ptyalin, &c., bodies which are capable of causing very definite changes in the chemical composition of the fluids in which they exist.

CONDITIONS OF LIFE.

The life of one of the schizo-mycetes, like the life of any other vegetable organism, depends on its sur-

roundings, and consequently the various forms of bacteria depend on food or soil, water, temperature, oxygen, and rest.

Food.—As regards food, each variety flourishes best on certain soils, and some organisms cannot grow at all in matter on which others flourish. All, or almost all, however, have this in common, namely, a preference for animal tissues of compound nature, being apparently unable to utilize crude substances, or to make use of elementary matter as food.

There can be no doubt that these organisms are very dependent on the soil in which they grow, and that minute differences in composition, such as cannot at present be detected, are of great importance to them. Thus Koch found that bacilli which grew, and caused fatal results in a house-mouse, could be injected into a field-mouse without causing it any harm; in the latter they could not live. Similarly, human individuals show the greatest differences in their susceptibility to certain diseases, *e.g.*, measles or erysipelas, and, whereas one person may be attacked three or four times, another equally exposed may altogether escape. It is also a matter of common observation that a depraved condition of the general health predisposes a person to disease, and it is highly probable that when a patient is "out of health" the composition of his tissues is for the time being altered, and affords a soil for the growth of organisms which the healthy body does not supply.

Water is necessary for the growth of all fungi, but all living animal tissues contain in themselves a sufficiency. Many forms of organisms are killed by drying.

Oxygen appears to be essential for the life of the schizo-mycetes. Some of them can obtain it from tissues in which it occurs as part of some compound substance; others are unable to extract it in this way, and require exposure to the air.

Temperature.—The temperature favourable for

the life of an organism differs much with the different varieties, whilst some of them are capable of surviving great alterations. The temperature of the human body is favourable for the growth of most varieties.

Rest.—Almost all fungi grow best when at rest, and many of them can be prevented from growing or multiplying by keeping the fluid in which they are suspended in a state of constant motion.

THE DISTRIBUTION OF THE SCHIZOMYCETES

is very wide. They are found in all water except that which comes direct from deep springs, in all soils as far as a depth of 3 feet from the surface, and in the air in the neighbourhood of animal or vegetable life. Air taken from a great altitude, and therefore pure, contains no organisms; but dust seen in a strong ray of light is formed largely of these minute parasites.

It is evident that if the surroundings of man are so impregnated with organisms the latter must easily obtain entrance to the body by the respiratory and alimentary tracts. And such indeed is the case. In every act of respiration they pass in numbers to the lungs, and during deglutition are carried into the stomach. Fortunately, however, the larger number of them are unable to find a suitable soil in the healthy and living tissues, the stability of which is too great to allow of their disintegration by the parasites, and, instead of causing any harm to the lungs or alimentary canal, the parasites, on the contrary, are themselves quickly destroyed. Many of them, however, are to be found in the stomach and intestines, and although they cannot act on living structures, nevertheless, when the patient dies, they speedily become active, and originate the process known as "decomposition," a process which always commences in the abdomen and the organs contained in it.

Numerous experiments have been made to deter-

mine whether these parasites are to be found in the tissues of the body, such as muscle, fat, &c., and though many observers have failed to discover them either by the microscope or by preservation at the body temperature in sterilized tubes, yet in some instances organisms have been found in tissues apparently healthy. It is probable that both bacteria and micrococci are taken up from the lungs by the leucocytes just as are the minute particles of carbon which stain the lymphatic glands, and it is almost certain that by the leucocytes the parasites are killed. It is, however, easy to understand that at the moment of death some organisms may be present which have not yet been rendered innocuous, and that in such cases, when the tissues are no longer alive, they will at once commence to grow, and will be found if searched for at a subsequent time.

It may thus be concluded that under normal conditions the schizo-mycetes do not find the living body a suitable soil, and that therefore they are incapable of growing in it or of exciting changes in its composition.

It must, however, be understood that there do exist certain varieties of organisms which can and do develop occasionally in the human body, and cause the production of certain materials which give rise to diseased conditions. Such organisms are distinguished as "**pathogenic,**" and will again occupy our attention.

PATHOLOGICAL IMPORTANCE OF MICRO-ORGANISMS.

The pathological processes which are originated by the action of micro-organisms are of the deepest interest to the surgeon, and the further investigations are pushed the more important does the subject become, for within the past few years many specific diseases have been shown to be the result of the action of one or other of the schizo-mycetes, and it is probable that

many others own a similar cause. One of the most important of the many fermentative processes is that known as **decomposition** or **putrefaction,** and may now be conveniently considered.

Decomposition is the result of the presence of the **bacterium termo,** an organism which is very widely distributed, which has constant access to the body under ordinary circumstances, but which has no power over living tissues, and rapidly dies when introduced amongst them.

In the absence of the bacterium termo dead tissues do not decompose, and may be kept for any length of time in sterilized, air-tight vessels and in "antiseptic" fluids, which act by preventing the growth and activity of the organism, and also cause its death. In the dry air of high altitudes also, and in very low temperatures, this bacterium cannot live, and thus animal tissues placed in ice or on high mountains do not putrefy.

On dead tissues and under favourable conditions of temperature and moisture the bacterium termo acts as a ferment, and produces, in the manner already described as common to all the schizo-mycetes, certain alkaloidal products called collectively **ptomains.** These products are extremely irritating to the living tissues, and excite in them an acute inflammation, which terminates in suppuration. The term **septic** has been applied to all such inflammations as result from the presence of decomposing material, whilst the constitutional conditions which arise if the **septic products** of decomposition are absorbed are well known under the name of "suppurative fever," "sapræmia," &c., and are treated of at length in other chapters.

It is thus evident that the bacterium termo is a pathological agent of great importance, and it must further be remembered that its action is not limited to large masses of dead tissue, but that it is equally potent in the smallest drop of fluid, so that serum, blood, or

pus may undergo putrefactive changes when extravasated in the tissues, and may thus excite inflammation and suppuration amongst them, whilst if the products of the putrefaction are absorbed the various constitutional states mentioned above will supervene.

Pathogenic organisms are characterized by their power of multiplying in and acting upon the living tissues, producing morbid chemical products, which, when absorbed, cause constitutional symptoms varying with the organism at work.

It is probable that some at least of the pathogenic organisms are really capable of acting upon healthy tissues, but it is quite certain that many of them only find a suitable habitat in those which have been injured, whose vital powers are lowered by inflammation, or by the occurrence of decomposition in their neighbourhood. In other cases a condition of general ill-health appears to predispose the body to attack.

The mode of action of the pathogenic bacteria differs according to the variety of the organism. Some grow into and accumulate in the minute blood-vessels, and, by mechanically plugging them, cause necrosis of minute portions of tissue. Others cause local acute inflammations and destroy the neighbouring structures, but the large majority probably act by producing certain morbid products, which, when absorbed, act as poisons to the various tissues with which they are brought into contact.

CHAPTER IV.

INFLAMMATION.

THE best definition of inflammation is that given by Burdon-Sanderson, who describes it briefly as "the succession of changes which occurs in a living tissue when it is injured, provided that the injury is not of such a degree as at once to destroy its structure and vitality."

It has been ascertained by experiments on various animals that the phenomena of inflammation are practically of the same nature wherever inflamed structures are found. It is therefore unnecessary to detail the various experiments alluded to, and we may pass at once to a description of the process itself.

CHANGES IN THE BLOOD-VESSELS AND THE CIRCULATION.

It is in the blood-vessels and their contained blood that the earliest of the changes which occur in inflammation are to be found. The first effect of any injury is a **dilatation** of the vessels—arteries, veins, and capillaries—a condition which is first noticeable and most marked in the arteries. The immediate result of this alteration in the calibre of the vessels is an increased supply of blood to the tissues, and at first an increase in the rapidity of the blood-stream. To this increased afflux the name **determination of blood** has been applied.

After a variable time the rapidity of the blood-stream diminishes, the retardation sometimes taking place very suddenly, and being first seen in the veins. As an immediate result, the current in the capillaries and then in the arteries becomes in turn slower, and pulsation is plainly visible in the smallest arterioles.

If attention is paid to the behaviour of the blood-cells themselves, it will be seen that during the stage of "determination of blood," the red blood-cells in the veins are swept along in the middle of the stream, in what is named the "axial current." The white cells float on the outer side of the mid-stream near the vessel-wall. When the blood-current becomes slowed, the white cells exhibit a marked tendency to adhere to the walls of the veins, and on account of this stickiness they gradually accumulate immediately inside the vessel. And not only do they tend to adhere to the vein-wall, but they also adhere to one another, and thus the vessel becomes lined by layers of leucocytes, which constantly gather fresh companions from the passing blood.

In this way the lumen of the vessel is narrowed, but at first the axial current sweeps by with unabated velocity. Gradually, however, this velocity is diminished, for the red blood-cells cohere and form rouleaux, and thus pass less readily through the smallest vessels. Finally, complete stoppage, or **stasis,** ensues, and the smallest veins and arterioles are seen to be filled with blood in which no movement takes place. If stasis persists, the nutrition of the vessel-wall is cut off, and it dies, with the result that its contained blood coagulates.

EXUDATION.

In any inflamed area the contents of the blood-vessels exude in greater quantities than in the natural state. It must be remembered that, in the ordinary

processes of nutrition of a healthy tissue, the parts around the vessels receive their supplies of new material from, and yield up their waste products to, the white blood-cells and the serum which are constantly traversing them after passing out of the smaller veins and capillaries. But in an inflamed area there is not only an increase in the amount of the exudation; there is also an alteration in its composition.

In the earlier stages of inflammation and in all inflammations of slight intensity there is merely an increase in the exudation of **serum,** a so-called **serous exudation,** in consequence of which the tissues become more succulent and œdematous, but are otherwise unaltered. The fluid, if drawn off, is found to be almost pure blood-serum, containing very few leucocytes and no coagulable material. The best example of a simple serous exudation is afforded by a blister. In the early stage of all inflammations the greater part of the exuded serum is removed from the inflamed area by the lymphatics, and experiments have shown that the flow in the lymphatic channels is thus greatly increased.

As the inflammation progresses and becomes more intense, so the character of the exuded fluid becomes altered. Instead of being watery or serous, it is coagulable and turbid, and to fluid such as this the name of **plastic exudation** is applied. It differs from the serous exudation in that it contains the fibrin-forming elements of the blood as well as numerous leucocytes. If drawn off it is found to form a firm white clot, and in the tissues also it coagulates. Fluid such as this is often called **"lymph,"** and may be seen to perfection in cases of plastic iritis, forming yellowish-white beads or drops in the anterior chamber and on the surface of the iris. On account of its coagulability its flow through the lymphatics is impeded, and after a time it clots in and occludes the lymphatic channels. As

an immediate result the tissues which these channels should drain become swollen with retained fluid, and, in consequence of the coagulation of the exudation, they become "indurated" and "brawny" in a manner which is typical of plastic inflammation, and is the common accompaniment of many deeply seated suppurations.

Diapedesis.—Even in the earlier stages of an acute inflammation, and also in inflammations of but slight intensity, the white blood-corpuscles escape from the smaller veins. The more advanced the inflammation, and the greater its intensity, the greater are the numbers in which they escape.

If a small vein be watched, it will be seen that soon after the slackening of the blood-current, and the adhesion of the white blood-cells to the vessel-wall, the contour of the vein is bulged at one or more spots. These localized projections gradually increase, and form rounded or button-like prominences on the outside of the vein. Soon they become further separated from the vessel, and appear to be attached to it by a stalk. Finally this stalk gives way, and it is now seen that a leucocyte has slowly worked its way through the vein and is free in the surrounding tissue. In this manner varying numbers of white blood-cells escape from the vessel, together with some of the fluid constituents of the blood.

The diapedesis of leucocytes is always first noticed in the veins, and then in the capillaries and the smallest arterioles. In very acute inflammations the red blood-cells as well as the white escape from the vessels, and sometimes in such numbers that the tissue may appear to be infiltrated with blood.

It will thus be seen that in inflammation any or all of the various constituents of the blood may escape. In slight inflammations, and in the earliest stages of the acute forms, only the serum exudes, but, as the inflammatory process progresses, the fibrin-forming elements, the white blood-cells, and

finally the red blood-cells pass into the surrounding tissues.

CHANGES IN THE INFLAMED TISSUES.

There is one change which is common to all inflamed tissues, and that is **softening.** If a piece of connective tissue in a state of inflammation be examined under the microscope, it will be seen that the fibres are swollen, and their outlines are blurred and indistinct. Separating the bundles of fibrous tissue and the individual fibres are numerous leucocytes, which are here and there collected into masses and render all other objects indistinct. It is probable that the softening of the tissues is due in part to absorption by them of the increased fluid exudation in which they are soaked, and also to the destructive or digestive action of the leucocytes, for in all acute inflammations the tissues undergo molecular death. Amidst the swollen and blurred structures, numerous capillaries are seen. Some of these are simply old channels which have become dilated and more distinct than natural; others are of new formation. All such newly formed channels originate from the pre-existing capillaries of the part. Their formation is described as follows:—One of the cells forming the boundary wall of a capillary throws out a protoplasmic process. This joins a similar process from another capillary, and the two vessels are thus united by a band of protoplasm, which, although at first solid, is subsequently hollowed out and permits the transit of blood.

The origin of the cells which are found in the inflamed tissues is a matter about which there has been much dispute, but may now be considered settled. They originate entirely from the leucocytes, whose diapedesis has already been described, and they increase in number by the escape of fresh cells from the vessels of the inflamed area, and also by fission.

Even in non-vascular tissues, such as the cornea, it has now been shown that the cells found in its sub-

stance when it is inflamed are not due to the multiplication of the corneal corpuscles, but to an infiltration of leucocytes from the surrounding parts. Thus, if the centre of the corneal surface be injured so that the anterior lamina is destroyed, the damaged part will become opaque, and, on examination after excision, the opacity is seen to be due to the presence of cells in the corneal tissue. These cells have not been exuded from any vessels in the inflamed area, for none such exist, and it was formerly considered that they resulted from proliferation of the corneal corpuscles themselves. It is now known that such is not the case, and that the cells are derived from the conjunctiva, for if the injury, instead of being a mechanical one, be caused by a chemical agent, such as chloride of zinc, in such a way that the anterior corneal lamina is not destroyed, then, although the corneal tissue is injured, no opacity will occur, for no cells can get into the damaged part from the conjunctiva. Further proof yet is supplied by excising a cornea, and placing the dead non-vascular tissue in the peritoneal cavity, for it will then be seen that, where the edges have been cut, marginal opacity results from cell infiltration. This, of course, can evidently not be the effect of multiplication of the corneal cells, for they are dead, and the cell proliferation must consequently be due to immigration of leucocytes from the peritoneal sac.

EXPLANATION OF THE CHANGES WHICH OCCUR IN INFLAMMATION.

The dilatation of the vessels and the increased afflux of blood which mark the earliest stage of the inflammatory process are due to the direct effect of the injury upon the vessels themselves. This dilatation is not a reflex change due to irritation of afferent nerve-fibres, for it can be caused by injury after the section of all nerves connected with the damaged part. It is due to an alteration in the tone of the muscular walls, and the injury acts either directly upon the muscle

itself, or else upon the nerve filaments which it contains.

The retardation and ultimate stasis of the blood-stream are the consequence of changes in the vessel-wall whereby the relations between the blood and the vessel become altered. As a result there is an increased resistance to the passage of blood through the vessel, a tendency to adhesion of the white blood-cells to the vessel-wall, and transit of greater numbers of them into the surrounding parts.

That these phenomena are due to changes in the vessel, and not to an alteration of the blood in the inflamed area, is thus proved:—If the ear of a rabbit be deprived of blood for twenty-four hours, and the circulation then restored, it is found that, in consequence of the cutting off of the blood-supply, the walls of the smaller vessels have become so much altered that all the phenomena of inflammation ensue, including dilatation of the arterioles and capillaries, followed by stasis and exudation. On the other hand, if, when stasis has commenced in an inflamed tissue, the engorged vessels are mechanically emptied of their contents, the white blood-cells which adhered to their walls traverse the rest of the circulation in a natural manner, and the rouleaux of red blood-cells break up, whilst, at the same time, if fresh blood be allowed to enter the inflamed area, stasis again occurs.

It is thus evident that the chief phenomena of inflammation are due to the **effect of the original injury upon the vessel-wall.**

In all acute inflammations, however, there is another and, from a surgical point of view, a most important factor in the retardation of the circulation in an inflamed part. This is the **tension caused by the exudation.** The more fluid that escapes from the vessels, and the greater the rapidity with which it exudes, the greater will be the pressure on all the more yielding structures around. Further, the more resisting the tissues, and the less capable they are of swelling so as to make room for the exuded material, the greater

will be the tension. As a consequence, the flow of blood in the vessels may be seriously retarded, and in some cases the retardation may be sufficiently extensive to cause the death of the surrounding parts. This is known as "sloughing" or "necrosis."

THE CLINICAL SIGNS OF INFLAMMATION

are swelling, heat, redness, and pain. Their occurrence may be briefly explained by reference to the pathological changes already described.

The **swelling** is the direct result of the increase of fluid in the part. The fulness of the vessels alone would account for part of the swelling, but most of the latter is due to the exudation of serum and liquor sanguinis.

The **heat** and **redness** are alike due to the increased vascularity of the inflamed area, and to the consequent transit of a larger quantity of blood than is natural. The increase of heat is always relative. The inflamed part is hotter than the corresponding portion of the body on the opposite side, but is never hotter than the blood itself, or than the mouth or the rectum. It is true that the local temperature may be raised to 100° or 101°, or higher, but when such is found to be the case, it will be found also that the general body-temperature is raised to a point at least as high.

Pain is due to pressure on, and stretching of, the peripheral nerves. It is always in direct proportion to the *tension* in the inflamed structures. Thus, in a part which can easily swell—*e.g.*, in the loose cellular tissue of the scrotum or of the eyelids—there is but little pain; but when inflammatory exudation occurs beneath tense structures, such as tendon-sheaths, tight fasciæ, periosteum, &c., pain is always very intense.

TERMINATIONS OF INFLAMMATION.

The inflammatory process may at any stage undergo **resolution.** The extent to which it will progress

depends, as will presently be shown, upon the nature of the injury, and the presence of decomposing material or of persistent irritation.

If resolution occur early, the hyperæmia may pass away even before stasis is reached; if later, the stasis may be broken up, the vessel may return to its natural condition, and the blood-stream may again resume its natural flow. If serum has been exuded into the tissues, it may again be absorbed by the lymphatics. If fibrin has been formed, it may be disintegrated and removed by leucocytes.

The leucocytes themselves are frequently entirely removed by the lymphatic channels, but in other cases they remain in the tissue, and in yet others, to be alluded to immediately, they may collect in sufficient quantities to form **pus.**

If the leucocytes remain in the tissue, they do not remain as such. They either develop or degenerate. In the former case they become elongated and spindle-shaped; after a time they become still more drawn out, their protoplasm fibrillates, and, uniting with other cells, **fibrous tissue** or **scar tissue** is formed. This development into fibrous tissue only occurs when the cells receive a sufficient blood supply for their nutrition. If this is not present, the cells degenerate, the fluid in which they lie is absorbed, and the cells are finally converted into either a caseous or calcareous mass.

CATARRH.—CATARRHAL INFLAMMATION.

Catarrh is a form of inflammation affecting epithelial surfaces, and, although more common in mucous membranes, occurs in the skin as "eczema." All catarrhal inflammations are characterized by the comparatively slight changes which take place in the epithelial cells, whilst the deeper tissues are involved in the destruction which is seen in all inflammatory processes. Catarrh may be excited by mechanical injuries, by exposure to cold or wet or to irritating

matters, as well as by certain constitutional conditions such as gout and scrofula.

In the early stage of catarrhal inflammation there is redness and hyperæmia, and then a serous exudation into the sub-epithelial cellular tissue, quickly followed by oozing of the fluid amongst the epithelial cells and its escape on to the surface.

In many cases no further change ensues in the connective tissue, but, in some, a plastic exudation, with formation of fibrin, results, and the affected part becomes more swollen and indurated, whilst in others the inflammation proceeds to suppuration, and pus-cells force their way between the epithelial elements, and are discharged from the skin or mucous membrane affected.

In the meantime, the epithelial cells themselves, being more tough and resistant than the softer sub-epithelial tissues, appear to derive actual benefit from the unusual vascularity of the deeper structures and the consequent increased supply of nourishment. They multiply with unusual rapidity, and, in the case of mucous membranes, secrete much more mucus than in their natural state; their secretion is necessarily mingled with the serum which exudes from the vessels below, and thus forms the copious watery and sticky discharge characteristic of mucous catarrh. In this discharge are found a certain number of leucocytes, and epithelial cells in varying numbers and of different shapes and sizes. When suppuration occurs, and the discharge becomes muco-purulent or purulent, many of the pus-cells may be seen to have made their way into the substance of the epithelial cells, and appear to have been formed by multiplication of the cell-nuclei, an appearance which is a deceptive one. If the inflammatory process continues, the epithelial cells are in time destroyed and an ulcerated surface is exposed. In such a case the inflammation ceases to be catarrhal.

Post-mortem examination shows but little altera-

tion in cases of acute catarrh, for the hyperæmia and swelling quickly subside after death. In cases of chronic catarrh, however, there is much pigmentation which results from the exudation of red blood-cells and disintegration of their colouring matter. This is well shown in cases of chronic cystitis, or during life in the legs of those who suffer from chronic eczema.

CHAPTER V.

SUPPURATION.

SUPPURATION, or the formation of pus, is the final result of all acute inflammations in which resolution does not occur. The pus may be contained in a cavity forming an abscess, it may be diffused, or may be discharged from a free surface, part of which has already been destroyed, and which is said to be in a state of ulceration.

ÆTIOLOGY OF SUPPURATION.

It has already been said that any injury may cause inflammation, but the essential characteristic of a simple traumatic inflammation is that *it is strictly localized to the seat of injury, and does not progress after the cause is removed.* A transient injury, therefore, however severe, will not cause an inflammation which will progress to the formation of pus, for, before that stage has been reached, resolution will have taken place.

There are two chief causes for the progression of inflammation to suppuration. They are—first, **the presence of organisms**; second, **persistent irritation of the inflamed part.** These conclusions are based chiefly upon experiments, to some of which brief reference may be made.

In order to show that, even after the most severe injuries, suppuration does not necessarily ensue, Professors Hueter and Hallbauer destroyed portions

of the muscle of a rabbit's thigh by either the actual cautery or by chloride of zinc. They found that, when antiseptic precautions were employed, scarcely any vascular disturbance took place, and the dead tissue did not act as an irritant.

Other experiments by Professor Chauveau took matters a good deal further. This experimenter showed that the subcutaneous twisting of the spermatic cord in animals, which is practised in France instead of castration, always results in the complete death of the testis, and that under ordinary circumstances the dead organ does not act as an irritant towards the tissues in which it lies. The operation, which is known by the name of *bistournage*, is performed by merely seizing and twisting the testis four or five times, the result being occlusion of the spermatic artery.

But although, under ordinary circumstances, no suppuration ensued, Chauveau showed that, if any septic matter was in the testis at the time of operation, pus was formed, and the dead organ was cast off. This was demonstrated as follows:—Some of the fluid from a septic abscess containing organisms was injected into a vein before the operation was performed. The organisms being thus circulating through the testis at the time that the cord was twisted, some of them necessarily remained in the organ after the operation, and in all cases where this injection was practised it was found that the tissues became filled with pus which contained numerous organisms. It then remained to prove that the suppuration was due to the presence of the micro-organisms in the testis, and not to the general contamination of the blood—a problem which was solved by performing the operation of bistournage *before* injecting the septic material, by which means, the spermatic artery having been occluded before the organisms were introduced, none of them could subtly enter it. In such experiments no suppura-

tion occurred, and it was therefore concluded that the presence of micro-organisms at the seat of injury alone was sufficient cause for suppuration.

But not only does suppuration result from an injury when the septic material is directly injected into the blood; it may also result from the ingestion of putrid liquid by the stomach and intestinal tract. Professor Kocher has shown that, in dogs, wounds of bone which are in a perfectly healthy condition may be made to suppurate, and diffuse osteitis may be caused by feeding the animal on putrid material, and there can be no reasonable doubt that such a result implies that micro-organisms introduced through the intestinal tract may contaminate a wound, and that thus the general condition of a patient may exercise much influence on the healing process.

This is abundantly illustrated by clinical observations; for not only do wounds seldom heal well when the patient is suffering from such diseases as pyæmia, erysipelas, &c., but in many patients in bad health, injuries such as slight contusions are followed by suppuration even in cases where no skin wound exists.

There is, however, another cause for the progression of any inflammation to suppuration, namely, **irritation.**

The inflammation set up by any transient injury will subside in the absence of septic infection, but if the cause of the inflammation be allowed to remain, if the injury be, so to say, long lasting, if, in fact, persistent irritation be present, then the inflammation will not be allowed to subside; it will progress, more and more exudation will take place, and pus will finally be formed. This has been well demonstrated by Chauveau, who found that if, after practising bistournage, the testis and surrounding parts were repeatedly manipulated, inflammatory changes resulted, and suppuration ensued, though the pus in such cases did not contain any micro-organisms.

Similarly in man, even in aseptic wounds, or in the case of damaged tissues which have never been exposed by any skin lesion, suppuration may ensue upon constant movement, want of rest, or irritation by some foreign body, the pus in such cases being sweet and not containing organisms. Thus suppuration may occur in cases of simple fracture not kept at rest, or after the injection of irritating liquids, such as iodine or strong carbolic acid, notwithstanding the aseptic nature of such fluids.

From the foregoing experiments, therefore, it may be considered proved—

First, that the most severe injuries do not of themselves cause suppuration in healthy tissues.

Second, that if the part injured be exposed in any way to septic influences, suppuration will ensue.

Third, that if the part injured be exposed to irritation, suppuration will ensue.

FORMATION OF PUS.

In describing the changes that occur in inflammation, it has already been noted that the white blood-cells accumulate in the softened tissues, and that numerous new blood-vessels run amongst the newly formed cells. Both cells and vessels are bathed in the exuded serum, and matted together by the coagulated fibrin. This vascularized tissue, rich in cells, is often called **inflammatory new formation,** and sometimes **interstitial granulation tissue.** If the inflammation progresses, the cells at the focus, or centre, of the inflammation increase, the tissues, in which they lie are gradually destroyed, and, finally, a a space or cavity is formed, bounded by the surrounding "interstitial granulation tissue," and containing leucocytes floating in a serous fluid. This fluid with its contained cells constitutes pus. The cavity containing it is called an abscess cavity, and the walls of the abscess cavity are formed by the "granulation tissue" already mentioned. An abscess

once formed increases in size by a continuance of the process by which it was originally developed. Around it is an area of inflammation extending for a variable distance. This inflammation spreads, and, as the inflammatory process progresses to suppuration, the abscess grows larger by a gradual liquefaction of the tissues around it. In all cases the pus tends towards the direction of the least resistance, and thus, a free surface being reached, the pent-up fluid finally escapes. An abscess which forms rapidly, and which is accompanied by all the signs of inflammation, is called an "**acute abscess**" and it has been shown by Professor Ogston that all such abscesses contain micrococci, which have, in cases where there is no wound, presumably reached the inflammatory area through the medium of the blood. Such organisms appear to be harmless when in contact with living and healthy tissues, and it is only when they gain access to a portion of the body whose vitality has been lowered or destroyed by injury that they are able to exercise their undoubted power of exciting suppuration. The pus of an acute abscess is never re-absorbed. It is practically dead tissue in a state of decomposition, and, acting as a foreign body to the parts around, prevents the inflammation from subsiding.

DIFFUSE SUPPURATION

is the term applied to an inflammatory process going on to the formation of pus which is not limited by the walls of any definite cavity. In such a case the diffusion may be the result of a very widespread injury, *e.g.*, general contusion of a whole limb; but in many instances it is due to septic organisms of more than usual virulence, and gradually passes into the specific inflammations known by the names of "cellulitis" and "phlegmonous erysipelas." In cases of diffuse suppuration there appears to be but little tendency

to the coagulation of the fibrin, which is the chief agent in limiting any collection of pus.

SLOUGHING AND GANGRENE.

In all inflammations the vitality of the tissues is lowered, and as suppuration progresses they die. In most cases the death is molecular, and the portions of dead tissue are so minute that, even if cast off in the discharges, they are not noticeable. More generally, however, the small dead particles are dissolved in the exudation—most probably by the leucocytes—and it is only in inflammations of great intensity, or where the inflammatory products are under great tension, that larger portions of the inflamed structures perish. Such dead portions are called "sloughs," and when still larger the part is said to be "gangrenous." The dead tissues are separated from the living by a process of ulceration.

CHRONIC ABSCESS.

A chronic abscess is one which is of slow growth, in which the signs of inflammation are but little marked. Such abscesses result either from long-continued irritation, or from an injury inflicted upon unhealthy structures. The process by which the pus is formed does not differ from that which occurs in acute suppuration, but, on account of the long continuance of the inflammation, many of the exuded cells remain in the part long enough to undergo further development, and thus the abscess-wall is liable to become greatly thickened by newly formed fibrous tissue. In some cases this thickening is so considerable that the pus becomes enclosed in a definite capsule, to which the name of "pyogenic membrane" has been applied. The pus of a chronic abscess in a healthy person does not differ from that of an acute abscess, except in that it contains no micrococci. The latter is a fact to be remembered, for so long as

all septic influences are kept away from the abscess-wall so long will the formation of pus remain slow, and so long will signs of acute inflammation be absent. If, however, such an abscess be opened without proper precautions, and septic matter be introduced, putrefactive processes will be set up, an acute inflammation of the whole abscess-wall will ensue, and pus will be formed in greatly increased quantities.

Chronic abscesses often attain great size, and may remain for many months or even years without undergoing any material alteration in size. In some cases, and especially when the exciting cause has been removed, the fluid portions of the pus may be absorbed, and the pus-cells may dry up and become converted into a caseous mass, parts of which may subsequently become calcified. When absorption is in progress, the contents of a chronic abscess present varying degrees of inspissation.

Occasionally, when the contents of an abscess have been apparently absorbed, there is a recurrence of inflammation after an interval which may amount to years, and pus is again formed. To such abscesses occurring in the site of past suppuration the term "residual" has been applied by Sir James Paget.

LYMPHATIC ABSCESS.

Lymphatic or cold abscesses are sometimes separated from the chronic variety on account of the greater rapidity with which the formation of pus in them takes place. They may indeed form very rapidly, and a case is recorded by Brodie in which he removed three quarts of pus from the thigh of a gentleman in whom it had collected in the space of three weeks. Such an abscess could scarcely be called "chronic," yet it differs from an acute abscess in the complete, or almost complete, absence of pain, redness, and heat. The walls of such abscesses are usually very thin, and their pus is often ill-formed and watery.

It is probable that many lymphatic abscesses are of tubercular origin.

HEALING OF AN ABSCESS.

As already mentioned, the pus of any acute abscess is dead and septic material, and, as such, acts as a foreign body to the tissues around it, and keeps up the suppuration. When, however, the contents of such an abscess have been discharged, and nothing remains to cause a continuance of the inflammatory process, the abscess-cavity is rapidly obliterated. This obliteration occurs as follows:—The granulating surfaces of the abscess-walls are brought into contact by the pressure exercised on them by the surrounding tissues, which have until now been mechanically distended by the collection of pus. This pressure is naturally greatest in the deepest parts of a wound, and thus it is in its deepest parts that the walls of an abscess are naturally first approximated. Such an approximation soon results in an actual growing together of the opposing layers of granulations, and a gradual obliteration of the abscess-sac from below upwards. If, however, the walls of the abscess are very thick, or the surrounding tissues are much matted together, the collapse of the abscess-sac will not take place, and pus will continue to be secreted from the granulating surfaces. But it does not follow that even in these circumstances healing will not occur, for the abscess-cavity may be in great part filled by a growth of fresh granulations and fibrous tissue, as in the process of healing of an ulcer. The slowness with which this process occurs, however, is well illustrated by the great length of time required to fill up the cavity of an abscess situated in an absolutely unyielding structure, such as bone, for here, the collapse of the sac being impossible, its walls cannot directly grow together.

In some cases an abscess does not altogether close, but, contracting to a narrow suppurating track, con-

tinues to discharge pus. Such a track is called a **sinus.** Sinuses are often long, narrow, and tortuous. They are lined by ill-formed granulations, and secrete thin, watery pus. Their walls are commonly thickened by fibrous tissue, and a bunch of granulations commonly sprouts from the orifice. Anything which keeps up irritation will cause a sinus. Amongst the commonest causes are the presence of foreign bodies, such as dead bone, portions of clothing, &c.; the retention of pus in an ill-drained cavity; constant movements by neighbouring muscles; and the passage of irritating matters, such as fæces or urine.

ULCERATION.

Ulceration is the term employed to indicate an inflammation of a free surface which has progressed to suppuration. The process by which an ulcer is formed does not differ in any way from that by which an abscess is developed. In each case, an inflammation having been started, exudation, formation of new blood-vessels, and softening of the surrounding tissues occur, and in each granulation tissue is developed and pus is formed. In the case of the abscess this pus cannot at once escape, for it is surrounded by granulation tissue on all sides; but in the case of an ulcer, the inflammation having occurred on a free surface, the pus escapes as quickly as it is formed, and the granulation tissue is found only in the "base" of the ulcer. It cannot be too clearly enforced that the section of the base of an ulcer and that of an abscess-wall possess precisely the same structure. Each is composed of "granulation tissue," and by each pus-cells are formed. If an abscess-cavity could be laid out on a free surface, it would form an ulcer; or if one ulcer could be placed over another so that the pus from each was shut in, a cavity lined by granulation tissue and structurally identical with an abscess would be formed. Ulceration is commonly said to mean "molecular death," and this is true. But it is also

true that suppuration means precisely the same, and that the gradual destruction of tissue already described in dealing with the formation of an abscess differs in no way from the "molecular death" of ulceration.

An ulcer, like an abscess, may result from persistent irritation, or from a septic condition of a wounded surface. In the case of a traumatic ulcer of the skin, the initial injury is often slight, perhaps an abrasion destroying the surface epithelium and exposing the papillary layer. Such a wounded surface would readily heal if not exposed to irritation by dirt or mechanical stimuli; but, if so exposed, the inflammation started by the injury progresses through the stages of hyperæmia, stasis, exudation, &c., and results in the formation of granulation tissue from which pus-cells are thrown off. If the irritation be kept up, or if septic conditions exist, the ulcer may spread, and the deeper structures will be gradually involved and will perish in the process of suppuration. After a time the ulcer ceases to extend, and either remains stationary or progresses towards cicatrization. Its stationary condition is unnatural, and is usually the result of a continuation of the irritation, but it may be due to various local conditions to which allusion will presently be made.

In describing any ulcer, attention must be paid to—

The shape and extent;

The floor and secretion;

The edges;

The surrounding parts.

Following this arrangement, we may now proceed to describe a **healthy, healing** ulcer, *i.e.*, one from which all irritating causes have been removed, and which is in process of cicatrization.

The **shape** and **extent** vary in different cases.

The **floor** is on the same level throughout, and is formed of innumerable "granulations," which give it a velvety appearance.

Examined more closely, each granulation is found to consist of a small papilla composed entirely of white blood-cells loosely held together by fibrin, and having in its centre a single, looped blood-vessel. All the granulations are of the same size, and are bright-red in colour. They are closely packed, and the whole base of the ulcer is evenly covered by them. Immediately below these granulations lie the tissues softened by the inflammatory process, containing exudation-cells and fluid, with many new blood-vessels. The more deeply we pass the less marked are the signs of inflammation, and, after passing through the areas of stasis and hyperæmia, we reach the healthy subjacent structures. In the deepest parts of the inflammatory area we find some newly formed fibrous tissue.

The **secretion** of a healthy ulcer is healthy pus. This is a thick, opaque, yellowish fluid of a creamy consistence, with a specific gravity of about 1030, and an alkaline reaction. If allowed to stand, it does not coagulate, but separates into two layers, the upper being clear and fluid, the lower dense and yellow. The clear fluid is identical in chemical composition with the liquor sanguinis. The denser layer is composed of "pus corpuscles." Examined microscopically, these are found to be round cells, generally granular, with a diameter of about $\frac{1}{2500}$ of an inch. They are escaped and dead leucocytes, and, being dead, have no amœboid movement.

The **edges** of a healthy ulcer are not raised, or indurated, or sharply cut; they slope gently on to the base, and where the edges and base join there is a thin bluish-white pellicle marking the line of the advancing epithelium, which is eventually to overgrow the whole ulcerated surface.

The parts immediately around a healthy ulcer are red and inflamed, but this inflammation is very slight, and limited to the immediate vicinity of the ulcer. The skin in the neighbourhood is healthy, and is

not congested, eczematous, œdematous, or otherwise abnormal.

HEALING OF AN ULCER.

It has already been said that so long as an ulcer is irritated so long it tends to extend, but, when all irritation has been removed, the inflammatory process becomes more limited, and **repair** commences. An ulcer implies loss of substance, and the first efforts of repair are directed towards filling up the gap made by the ulcerative process. Until this gap is filled up, *i.e.*, until the base of the ulcer is raised to a level with its edges and with the surrounding parts, the process of "skinning over" does not commence.

The gap is filled by fibrous tissue, which is formed from the exuded leucocytes. In the deeper parts of the granulations many of the cells which are exuded remain in the tissue, and, together with their neighbours, develop into fibres in the manner already described. Fresh granulations are now formed, and new loops of blood-vessels shoot up towards the free surface, and thus, by a constant development of the cells in the deeper parts of the ulcer, and an equally constant growth of fresh granulations, the base of the ulcer is raised to the level of the surrounding parts. When this is accomplished, the epithelial cells at the edges grow over the ulcerated surface, and gradually cover it in. At first the epithelial covering is very thin, and the granulation tissue beneath, shining through, gives it a bluish-white appearance. Later on, when the epithelium is thicker, and the subjacent structures have lost their vascularity, the "scar" or "cicatrix" is of a pearly-white colour.

It is the special characteristic of all newly formed fibrous tissue that it tends to contract, and, as a consequence, the scar tends to diminish in size for long after the skinning-over process is complete. It is probable that this contraction is merely the result of lessened vascularity, for by the time that the

epithelium has grown over the ulcerated surface, the numerous newly formed blood-vessels, having fulfilled their purpose of bringing up material to fill the gap, shrink and disappear. The young fibrous tissue consequently becomes more dry, and shrinks, and thus produces the characteristic contraction of all scar tissue. The result of this contraction is that the neighbouring parts tend to be drawn in towards the scar, and, on the extent to which they can be drawn in, even more than on the size of the original ulcer, the extent of the resulting cicatrix will depend. Thus, in extremely lax tissues, such as the scrotum and eyelid, large portions of skin can be removed with scarcely any scar resulting; but where the skin is tense, as, *e.g.*, over the front of the tibia, the scar of an ulcer is always relatively large.

When the whole thickness of the skin has been destroyed it is not reproduced, and the epithelial covering of the cicatrix is devoid of papillæ, hairs, sebaceous and sweat glands.

CHAPTER VI.

HEALING OF WOUNDS.

ALTHOUGH wounds are generally described as healing in four or five different ways, yet, in all, the process by which they are finally closed is the result of **inflammation.** It will be remembered that we have already defined inflammation (p. 20) as "the succession of changes which occurs in a living tissue *when it is injured*, &c.," and thus it may be said that every injury carries with it its own cure, for in all alike the healing process is of inflammatory origin, and is the direct result of the injury.

It is true that even within very recent years "healing by immediate union" has been described, but this is a process which may be said to have no pathology, for in it the severed tissues are supposed to simply join without the intervention of any uniting material whatever. Thus, one piece of muscle would become attached to another piece, one end of a cut vessel to another, and so forth. It is probable that this never really occurs, and that in all cases there is some intervening plastic material, however small in amount.

HEALING BY FIRST INTENTION

is healing without the formation of pus, and is best seen in cases of surgical operations, where healthy soft tissues have been cleanly divided by a sharp knife, *e.g.*, in operations for hare-lip or in flap amputations.

If, in such a case all hæmorrhage is arrested, and the parts are brought into complete apposition, the following changes may be noticed:—

The edges of the wound at first become slightly red and swollen, the latter condition being often well demonstrated by the "burying" of the sutures which have been originally quite loosely tied, but which subsequently become tightened by the swelling of the soft parts. Following this there is some increase of heat and pain, and thus it will be seen that all the signs of inflammation are present, though all in a very slight degree, and strictly limited to the immediate neighbourhood of the wound. In the first few hours there is often a little oozing of serous or plastic fluid, but after the second day, or earlier, the pain, redness, heat, and swelling subside, and a thin red line is the only indication of the previous injury. Next, the redness of this line fades, and finally a narrow white streak or "cicatrix" remains.

A closer investigation of the process shows that, in the absence of all sutures, the cut surfaces are within a few hours held together by some glutinous substance, and that with care they may be separated without the necessary causation of bleeding, the non-vascular uniting medium being fibrin, which has been exuded from the vessels in the immediate neighbourhood of the wound. Twenty-four hours later the uniting material has become vascularized, and any attempt to separate the cut surfaces will excite hæmorrhage, whilst, later still, the newly formed blood-vessels shrink and disappear, and the scar becomes absolutely non-vascular.

A microscopical examination of the wound affords an ample explanation of these clinical observations.

The immediate result of the injury is to set up those changes which are characteristic of the inflammatory process, and, consequently, the parts in the immediate neighbourhood of the wound become the *seat, first of hyperæmia,* and then of stasis, exudation

of liquor sanguinis and of leucocytes, formation of new blood-vessels, and softening of the inflamed tissues. In each flap there is a development of the "inflammatory new formation" or "interstitial granulation tissue," already described, and between the flaps, and into the uniting fibrin, cells are exuded. These changes are quickly followed by the formation of loops of new blood-vessels and of granulation tissue between the flaps, which are in fact, as it were, melted into one another, in the same way as two pieces of sealing-wax may be united if heated and held in apposition, the inflammatory process softening the tissues in the same way as the flame softens the sealing-wax (Billroth).

FIG. 4.

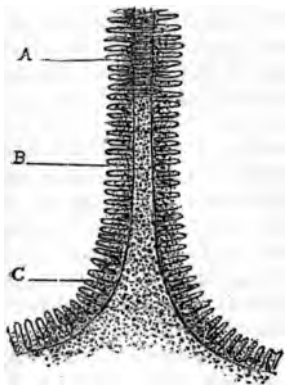


Diagram of a Healing Wound. At B the space between the flaps is filled with cells, which at A have become developed into fibrous tissue, and at C are accumulating in such numbers as to separate the flaps and form pus.

Now, it has already been shown that in healthy tissues no inflammation will progress to suppuration if the injured part is not irritated either by mechanical means or by the presence of septic material; so that in the wound in question, whilst the initial injury is alone capable of exciting a sufficient amount of inflammation to promote its healing, if no irritant be subsequently applied resolution will shortly ensue, and the inflammatory process will subside. If such be the case, the exudation of cells and liquor sanguinis, and the formation of new vessels, will cease, for sufficient material has now been provided for the repair of the injured part. Next, those cells which

e between the flaps, as well as those which lie in the oftened tissues of the flaps themselves, will develop nd form fibres, and finally the wounded surfaces ill be united by a firm scar of non-vascular fibrous issue.

Healing by scabbing.—Healing by scabbing is ealing by first intention. The scab is formed by blood-lot, which is often held more firmly than it otherwise ould be by being matted with hair and sometimes ith other foreign bodies. The scab plays the part f a natural "dressing," and, by preventing mechanical ritation and infection by septic material, promotes ealing without the formation of pus. In some cases he scab fails to prevent suppuration, and when it ecomes separated a drop or two of pus is found eneath it, covering over an ulcerated surface—heal-ng by first intention has failed, and union by granu-ation is in progress.

HEALING BY SECOND INTENTION, OR HEALING BY GRANULATION.

Healing by second intention is healing with forma-ion of pus. If a wound about to heal by granula-ion is watched, it will be seen that the same changes ccur in it at first as in the wound healing by first ntention, but that as time goes on the signs of in-lammation, instead of decreasing, become more narked, that the redness and swelling extend, and hat the discharge, which originally consists of serum r of lymph, instead of soon drying up, increases in uantity and changes its character, for, though it is t first merely stained with the blood-colouring natter derived from disintegrating clots, it afterwards ecomes thicker and whiter, and finally consists of pus.

At first the edges of the wound are united by fibrin, ut, as suppuration progresses, the pus gradually ollects between the flaps, and after a time com-letely separates them and exposes granulating urfaces.

Microscopically examined, the same changes are at first noticed as in healing by first intention. Instead, however, of the inflammatory process stopping short at the production of just a sufficient number of cells to unite the wounded surfaces, it progresses. More and more cells and fluid are exuded, the uniting fibrin, the interstitial granulation tissue, and the softened tissues of the flaps become completely liquefied, and finally the flaps are separated, and their "granulating" surfaces are exposed. It will thus be seen that up to a certain point the processes of healing by first and by second intention are identical. The cause of the suppuration in the second case is to be found in the presence of either a mechanical irritant or of septic matter. Some foreign body may be in the wound, serum or blood may be retained under tension, or a portion of dead tissue may remain and decompose, and so the inflammation will progress instead of undergoing resolution.

A granulating surface being thus exposed, it in many cases proceeds to heal in exactly the same way as an ulcer, *i.e.*, by organization of the cells in the deeper parts into fibrous tissue, and by a constant formation of fresh granulations until the surface is reached.

In other cases healing by third intention takes place.

HEALING BY THIRD INTENTION, OR UNION OF GRANULATIONS.

This method of healing is really far more common than is usually supposed, and consists in the approximation and union of the opposed granulating surfaces, all irritating matter which originally caused suppuration having been first removed. Such a mode of union has already been described as taking place between the opposing walls of an abscess after evacuation of its contents, and constantly occurs in the deeper parts of all granulating flap-wounds, though, on account of the fact that it cannot be seen in

actual progress, it has scarcely obtained sufficient prominence.

Healing of lacerated and contused wounds.—In lacerated and contused wounds, not only is the initial injury greater than in clean cuts, but small portions of the damaged tissues are usually injured beyond repair, and die. These dead portions, being in contact with the living parts, and often infiltrated with septic material, act as foreign bodies to the tissues amongst which they lie, and cause suppuration. On account of these reasons lacerated wounds can never be expected to unite by first intention, for before healing can occur the dead parts or sloughs must be separated. After this has taken place, the wound heals by second or third intention in the manner already described.

THE EFFECTS OF DRAINAGE OF WOUNDS.

In all large wounds it is customary to provide for the free escape of any fluids that may collect in the injured parts. This provision for the escape of fluid is spoken of as "drainage."

In what has been written above of the changes observed during the union of wounds, the escape of serous and plastic fluid, and in other cases of pus, has been mentioned as of usual occurrence. This fluid is derived in part from the contraction of clots and the squeezing out of serum, but in much greater part from the exudation which is the necessary accompaniment of all inflammation. In cases where large raw surfaces are left, as after amputations, the amount of this fluid is very considerable, and if no exit were allowed it would collect between the flaps, and, by mechanically separating them, and causing tension, would effectually prevent union by the first intention—a trouble which is obviated by the use of drainage-tubes during the first day or two after operation. But not only does retained fluid prevent healing by mechanically separating the parts; it also *provides an admirable* medium for the develop-

ment of any micro-organisms that may gain access to it.

It has been shown by Wegner that fluid containing micro-organisms may be introduced with impunity into the peritoneal cavity of an animal so long as no more fluid is used than can be readily absorbed. If, however, more fluid is injected than can be absorbed, it causes an accumulation in the peritoneal cavity, and peritonitis supervenes. The explanation of this is obvious. The unabsorbed fluid quickly becomes charged with animal matter by osmosis, and in this the micro-organisms rapidly develop, and cause putrefactive changes. When only a little fluid is used it is rapidly absorbed, and the micro-organisms coming into direct contact with living and healthy tissues are immediately destroyed.

There is therefore a great difference between exposing to contamination an open granulating surface and one which is closed. Thousands of people, for instance, go about their daily work with large ulcers on their legs, freely exposed to dirt of all kinds, and septic in the extreme, yet no harm comes, for any organisms which may gain access to the ulcerated surface are either destroyed by the granulations or quickly washed away in the discharge, and get no opportunity of exciting putrefactive changes. On the other hand, if but a few bacteria gain access to the retained fluid in an amputation wound, they will rapidly multiply in it, will cause decomposition of the fluid, and will form material which, if absorbed, will cause severe constitutional symptoms.

CHAPTER VII.

TRAUMATIC, SUPPURATIVE, AND HECTIC FEVERS.

Traumatic fever is a fever due to an injury. Suppurative fever is a fever occurring in connection with the formation of pus.

TRAUMATIC FEVER.

If any severe injury is inflicted on a healthy person, the temperature, after a transient depression dependent on "shock," often rises above the normal, and continues to ascend for about twenty-four to forty-eight hours, usually attaining its highest point on the evening of the second day. The increased rapidity of pulse and respiration, the dryness of the skin and of the mouth, the furred tongue, constipated bowels, and scanty, acid urine, which are the usual accompaniments of fever, are all present. After the second day the temperature descends, and, as a rule, the fever has run its course by the fourth or fifth day. It never continues more than a week. Traumatic fever such as this has no connection with any septic condition of a wound. It is the direct result of changes set up by the injury itself, and, provided that nothing intervenes to alter its course, will reach its height and then subside in a perfectly definite manner.

The **causes** of this form of fever have been variously explained. The first and oldest theory is that it is *due to the increased temperature* of the parts which

have become inflamed as the result of the injury. This, however, is not true, for, as has already been mentioned, the increased temperature of the inflamed part is only relative, and never exceeds that of the blood. It is therefore not possible that the latter should become heated by its transit through the inflamed area.

The second theory is that the fever is caused by the absorption of the products of inflammation. Any substance which, when inoculated, causes a rise of temperature is said to be "pyrogenous," and it has been shown that the ferment which is present during the formation of fibrin belongs to this class. It is therefore probable that the absorption of inflammatory products independently of any septic contamination may cause fever.

The third theory is that the fever is of nervous origin—that the irritation of the peripheral nerves at the seat of injury, either mechanically or by implication in the inflammatory process, may reflexly cause the production of a greater amount of heat throughout the body. No doubt need be entertained of the possibility of such a mode of production of heat, for it finds a parallel in the normal physiological processes by which the temperature of the body is maintained at a uniform level, and it is certain that, in some cases at least, traumatic fever is of neurotic origin. Thus, in cases of simple fracture the temperature frequently rises within an hour or two of the receipt of the injury, when there has scarcely been time for the absorption of inflammatory products. And, again, in many other cases a splint, tightly applied, or inflicting pain, is the cause of an attack of fever, which immediately subsides after the removal or loosening of bandages and strapping. In another variety of traumatic fever, to which the name of "urinary" or "urethral" fever has been applied, the fever is the direct result of irritation of, or injury to, the urinary *tracts, and especially* the male urethra. In some

patients the passage of a catheter, which in no way injures the mucous membrane, is immediately followed by a rigor and faintness, with much shock, succeeded by a rise of temperature of several degrees, which in its turn usually quickly passes away, the attack being evidently throughout of a neurotic nature.

It is thus clear that traumatic fever runs its most typical course when a wound is healing by first intention, that it is independent of any septic changes, and may be, and often is, present in injuries unaccompanied by any open wound at all.

If a wound does not heal by first intention, and pus is formed, the traumatic fever, instead of subsiding, is liable to continue, and to pass gradually into suppurative fever.

"SUPPURATIVE FEVER."

This form of fever, unlike that which precedes it, attains no definite height and runs no definite course, for, unlike the former, it is not dependent upon a single and transient cause, but is liable to last so long as the suppuration persists.

Cause.—The same causes that produce traumatic fever may also influence the course of suppurative fever, but the most important and most active cause of the latter is undoubtedly the **absorption of "pyrogenous,"** or heat-producing, **material** from the wound. It has been already mentioned more than once that the cause of suppuration is either mechanical irritation or the presence of septic matter. Now, the pus which is formed as the result of mere mechanical irritation has little more pyrogenous properties than has fibrin ferment, but the pus which is contaminated by septic material is in the highest degree pyrogenous. In speaking of drainage of wounds, it has already been said that the retained products of inflammation form a most favourable medium for the *development* of micro-organisms, and *if pus which is at first perfectly* healthy is submitted

to the action of the organisms capable of promoting putrefaction, it will soon be found that the latter have produced in the previously almost innocuous pus morbid products which, if injected, will cause all the symptoms of severe suppurative fever. If, however, a free exit is given to all the products of inflammation, first, they will not be absorbed at all, and, secondly, they will not remain sufficiently long exposed to the action of micro-organisms to become contaminated before being discharged from contact with the tissues capable of absorbing them.

It is thus evident that suppuration may occur, and large quantities of pus may be formed, and yet no "suppurative fever" may be present. The occurrence of the latter is due to the **retention** and **absorption** of altered inflammatory products rather than to their formation.

Just as traumatic fever fades into suppurative fever, so the latter fades into hectic fever.

"HECTIC FEVER."

The special characteristic of hectic is the marked periodicity of the rise of temperature, which always attains its greatest height towards evening, and then, after perspiration more or less profuse, gradually sinks, sometimes becoming normal, but often remaining persistently a little higher than natural.

This form of fever is almost invariably the result of long-continued suppuration, but whether it owns the same or similar causes as traumatic and suppurative fevers, or whether it has an altogether different origin, cannot certainly be stated. Its pathology is as yet obscure.

CHAPTER VIII.

SEPTICÆMIA AND PYÆMIA.

SEPTICÆMIA is a constitutional condition resulting from absorption of septic matter, and runs its course without the development of secondary metastatic suppurations.

It has already been mentioned that the chief cause of suppurative fever is the absorption of the products of decomposition from a septic wound, and septicæmia is to be regarded as simply a severe form of suppurative fever, which is also the result of absorption of septic matter from an inflammatory area. The agents at work in causing decomposition in all animal substances are micro-organisms, and in septicæmia also the poisonous material results from the action of these organized ferments. It has, however, been shown by experiments on animals that two separate conditions exist which have previously been included under the one name of septicæmia, and before proceeding further it is necessary to elucidate this point.

In all decomposing animal fluids certain alkaloids are found, to which the general name of "ptomaines" has been applied, and one of these, to which the name of sepsin has been given, was supposed by its discoverer to be the sole cause of septicæmia. This supposition is no longer entertained, for there is every reason to believe that the other alkaloids are quite as injurious. If fluid taken from a decomposing wound, and therefore containing ptomaines, be first

of all carefully filtered and thereby purified from the numerous micro-organisms which it contains, and then injected into an animal, it is evident that the latter is inoculated, not with the organisms themselves, but with the products of their action on animal matter. To the poisoned condition which results the name of **sapræmia,** or **septic intoxication,** is applied.

The chief symptoms of this are slight muscular twitchings and loss of power, with great restlessness, vomiting, and diarrhœa. The temperature rises, the breathing becomes difficult, and finally death ensues from cardiac weakness. Such is the course of events if a sufficiently large dose has been given, and, when an excessive quantity has been injected, the animal may die in an hour or two. When the dose is but small, recovery follows after a slight febrile attack. The course of events is entirely analogous to what is seen when any other active unorganized poison, such as strychnia, aconitia, &c., is administered. If the dose is large enough, the patient dies; if not, the poison is excreted, and he recovers. In the case of sapræmia, then, the process is not infective; the poison is as incapable as is strychnia of multiplying in the body, and consequently, if a drop or two of the blood of the animal experimented on be injected into another animal, no effects are produced, for the quantity of the poison used is but infinitesimal.

Septic infection, or **true septicæmia,** differs from sapræmia in the essential particular that it is a true infective process. It is experimentally produced by injecting putrid fluid, together with the various micro-organisms contained therein. The bacterium termo, the most active of the common micro-organisms in producing decomposition, does not appear to be the cause of septic infection, for it is incapable of acting on living tissues, and in their presence is soon itself destroyed. It is therefore probable that some other and more active organism, capable of living and

multiplying in the blood—a pathogenic organism—is the cause of septicæmia, and Koch has indeed shown that, in the case of mice, such an agent exists, namely, a very slender bacillus, which, if introduced into a mouse in the smallest quantities, multiplies with extreme rapidity, and quickly causes the death of the animal. If the point of a knife be dipped into the blood of a mouse which has died from this cause, and a slight scratch be inflicted on another mouse, the latter also dies with similar symptoms. The poison, then, is infective, and the symptoms do not depend, as in the case of sapræmia, on the amount of the dose, for, however minute the latter, the bacilli are capable of indefinite multiplication, and will thus in time produce a sufficient amount of poison to cause death. The chief symptoms are extreme feebleness and languor, with gradual slowing of respiration. The animal dies quietly, without any dyspnœa or struggling.

Sapræmia, as it occurs in man, generally results from absorption of considerable quantities of decomposing matter in cases where pus and the other products of inflammation have been retained under tension. Thus, it may be caused by decomposition and retention in the uterus of the fluid discharge which follows parturition, or by the retention of pus between the flaps of a septic stump.

Septicæmia, on the other hand, may be produced in man, as in mice, by a slight prick with any weapon which has been dipped in septic material, and is particularly prone to follow such injuries as dissection and post-mortem wounds, or the injuries sustained by butchers and others who have to deal with dead animals. The amount of poison introduced may be infinitesimal, but it can increase in the body to an almost indefinite extent.

It is evident that, in the case of sapræmia, if the dose has not been large enough to kill, the patient may readily recover if the cause of the poisoning is

removed, *e.g.*, if the retained pus is evacuated. On the other hand, in true septicæmia, even if the cause be removed, the patient is likely to die, as the micro-organisms, once introduced, continue to multiply.

The **symptoms** of septic intoxication in man cannot practically be separated from those of septic infection, and it is probable that, in many cases, the two diseases co-exist. They would never have been differentiated except by experiments. The symptoms, and the course they run, can scarcely be considered at length in the present work, but it may be briefly stated that, after an initial rigor of long continuance and unusual severity, there follows extreme depression of all the vital functions, and most noticeably of those of the central nervous system. All the secretions are dried up, and urine may be completely suppressed. The secretion of pus shares in the general disturbance, and any wound that there may be becomes dry, and is sometimes covered with a yellowish rind.

The circulation is greatly interfered with, especially in the smaller capillaries, and in many parts of the body congestions and actual stasis result. The blood may also escape from the vessels, and may form small ecchymoses or petechiæ. These may be seen in the skin, but are much more common on mucous and serous surfaces. If a drop of blood be drawn off during life, microscopical examination shows that some of the red blood-cells are already undergoing disintegration, and that all of them exhibit a great tendency to cohere and form solid masses. The breaking up of the red blood-cells indicates that the poisonous material actually possesses the power of destroying the essential elements of the blood, whilst the cohesion of the cells also explains, in part at least, the tendency to stasis and congestion.

On post-mortem examination, decomposition is found to be far advanced, and rigor mortis frequently *but little marked*. Incisions into the muscles of *the chest and limbs* show that the latter are stained

by the blood-colouring matter which has escaped from the disintegrated cells. On opening the chest, petechiæ may be discovered on the pleuræ and pericardium. The heart-substance is stained as are the voluntary muscles, and, like them, it is extremely soft and tears easily. The blood in the heart-cavities and throughout the body is of a dark tarry colour, and is either fluid or only imperfectly coagulated. The lungs are very congested and lacerable. The peritoneum may present petechial spots, and the liver, spleen, and other viscera are all darkly congested and very friable.

PYÆMIA.

Pyæmia is a constitutional disease due to absorption of a septic poison from injured tissues, and is characterized by the development of numerous secondary metastatic inflammations.

In pyæmia, as in septicæmia, it is probable that a definite form of organism produces the poisonous or septic matter, the absorption of which into the system gives rise to the general or constitutional symptoms of the disease. In both pyæmia and septicæmia alike the wound which is the seat of inoculation is generally of recent origin, and wounds which are granulating are rarely infected.

The earliest symptom of pyæmia is a rigor, but, whereas in septicæmia the rigor is never repeated, pyæmia is characterized by frequent rigors. The length of time that pyæmia takes to run its course varies greatly in different cases. In some, the patient dies in three or four days; in others, not for weeks or for months. Even the most rapidly fatal cases survive longer than do those of septicæmia. The most frequent complications are broncho-pneumonia and pleurisy, pericarditis and endocarditis, abscesses scattered throughout the body, painful swellings and suppurations of joints, peritonitis, and

thrombosis of the veins in the neighbourhood of the seat of inoculation.

On post-mortem examination, the muscles may be found more or less stained as in cases of septicæmia. The lesions most commonly found comprise the following:—On opening the thorax, the pleuræ contain considerable quantities of dark, dirty-brown, foul, blood-stained fluid, often mixed with quantities of pus and shreds of fibrin. Similar fluid distends the pericardium, and the surface of the latter membrane is rough and shaggy with recent lymph.

On removing and washing the lungs, small raised patches, varying in size from a pea to a walnut—and seldom larger—may be seen close beneath the pleural surface. The smallest of these are dark in colour, the largest opaque white. If the former are incised, they are found to consist of very darkly congested patches of lung-tissue, into which a small amount of blood has been extravasated. If one a little bigger is chosen for incision, it will be seen that in the centre of the darkly congested area there is a drop or two of pus, whilst all the swellings larger than a hazel-nut are nothing more than abscesses. On making sections of the lung, patches of broncho-

FIG. 5.

A Small Vessel in the Lung completely plugged with Micrococci. From a case of pyæmia.

pneumonia will usually be found, and there may be *pus in the smaller* tubes. No abscesses, however, are

usually found deep in the lung itself; they are confined to the pleural surface.

A microscopical examination shows yet more, for the vessels in the thrombosed area are found to contain numerous micrococci, which in some of the smaller capillaries are in such numbers that they alone are sufficient to arrest the passage of blood (see Fig. 5).

On opening the heart, endocardial inflammation or small abscesses in the heart-muscle may be found. The peritoneum may contain fluid similar to that met with in the pleuræ and pericardium, but its occurrence is not nearly so frequent as in the latter situations. The spleen is large, soft, and friable; the liver is in a similar state. Either viscus, as well as the kidneys, may contain abscesses. If one of the joints which has been swollen and painful is laid open, it is found to be distended with thin oily pus. Frequently the cartilages and synovial membrane look quite healthy and shiny; in other and rarer cases they are ulcerated, and the bone is exposed. Abscesses may be found in different parts of the body, being specially common in the parotid regions. Wherever pus occurs it contains micrococci.

An examination of the wound will generally reveal the presence of retained pus, which is often foul. The veins in the neighbourhood are sometimes filled with clot, and thrombosis may extend for a considerable distance. The clot is always ill-formed, friable, and disintegrating. Frequently, in parts which are the most broken down, either semi-purulent fluid or true pus may be found. The vein-wall may be roughened or ulcerated.

EXPLANATION OF THE SECONDARY ABSCESSES.

Such are, briefly, the post-mortem appearances of a case of pyæmia. Some of them—*e.g.*, the inflammation of the serous and synovial surfaces—may be explained by the poisoned condition of the blood, but it is

evident that the abscesses in the different viscera require further explanation. The first thing to notice about them is their locality. They are far more frequently met with in the lungs than in other viscera, and, wherever they occur, are situated at the periphery of organs and in the neighbourhood of the smallest capillaries. This at once suggests an embolic origin, and the source of embolism is readily found in the thrombosed veins. If an embolus derived from one of the valves of the heart, or from a healthy clot, and consisting simply of a piece of fibrin, be lodged in the terminal branches of any visceral artery, it will cause a complete stoppage of the blood-stream, with secondary congestion, but in no case will suppuration ensue. The abscesses of pyæmia cannot, then, be accounted for by the lodgment of simple emboli. No; the *condition of the clot* in the veins furnishes the necessary clue. The wound has been the seat of certain septic changes due to the presence of micro-organisms, and septic matter has been formed in it. Similar changes have occurred in the veins and their contents. The clot is not a simple thrombus; it is a poisoned one, and contains micrococci, and because it is so poisoned therefore it disintegrates. The abscesses now are easily explained. The clot in the vein breaks up, and minute portions of it, being washed away, are carried by the venous blood to the right side of the heart, and are thence propelled into the pulmonary circulation. In the smallest capillaries these emboli lodge, and in the vessels and the neighbouring lung-tissue the micrococci excite exactly the same septic changes as were occurring in the wound from which they have been directly derived. The emboli are not simple; they are *infective*.

The abscesses in the other viscera are similarly accounted for. Either some of the particles of clot from the original seat of thrombosis are not detained in the lung-capillaries, and, reaching the left side of the heart, enter the systemic circulation, or, as is much

more probable, fresh emboli are derived from disintegrating clots formed in the pulmonary veins around the scattered abscesses. The embolic nature of the abscesses in question is further exemplified by noting that, in cases of pyæmia following injuries or operations about the rectum, the abscesses are most frequent in the liver, and not in the lungs—a fact which is readily explained when it is remembered that much of the rectal blood enters the portal and not the systemic system of veins.

It will thus be seen that, in pyæmia, there is not only septic fluid absorbed from the wound, but solid particles of poisoned clot are scattered by means of the circulation, and it is these solid particles which give rise to the metastatic suppurations which are typical of the pyæmic state.

It has seemed better to deal with septicæmia and pyæmia as though they were always separate and distinct diseases, but it would be erroneous to suppose that such is the case. No doubt typical instances of the one differ both clinically and anatomically from those of the other, but frequently no hard-and-fast line can be drawn. Thus, in typical septicæmia there is but one rigor, and death ensues very rapidly; but in other cases there are several rigors, and the patient may live a week or ten days, yet a post-mortem examination shows the lesions of septicæmia alone, and none of the multiple abscesses of pyæmia. Again, a case which, at first, at any rate, looks like one of septicæmia may, after death, exhibit numerous disseminated suppurations. It is on account of such cases as these that many authors express the belief that the diseases are really one and the same, and that the disintegration of septic thrombi is to be considered as a chance occurrence in the course of a case which would otherwise be one of simple septicæmia.

Other writers believe that, in mixed cases, there are two separate poisons formed in the wound, and

that each produces its own effects. The question is one of much difficulty, and is not yet finally settled, but it does not seem advisable to pursue inquiry further in the present work.

The conditions of wounds and of patients which predispose to the development of the diseases in question are identical. Overcrowding, insufficiency of fresh air and good food, the presence of large numbers of suppurating wounds in the same room or building, are the most important. Wounds of veins or of bones are more frequently followed by both pyæmia and septicæmia than injuries of other parts of the body, whilst the retention of decomposing pus and other inflammatory products is always a fertile source of such affections.

CHAPTER IX.

ERYSIPELAS.

Erysipelas is essentially a spreading inflammation. It most usually attacks the skin, but may also occur on mucous, serous, and synovial surfaces. It is probable that it always commences in a wound, for cases of so-called idiopathic erysipelas affect almost invariably some exposed part of the body, such as the face, where small abrasions are common. The disease is the result of a local infection, but, although the chief apparent effect of the inoculation is also local, there is always at the same time a more or less severe constitutional disturbance. It will be convenient to describe erysipelas as occurring on cutaneous surfaces, for here it is at once most frequently met with, and is seen in its most typical forms.

Three varieties of the disease are described :—

Cutaneous erysipelas.

Cellulo-cutaneous or **phlegmonous erysipelas.**

Cellulitis.

In each of these the first symptom is a rigor, with rise of temperature, followed by sweating. Any existing wound assumes an unhealthy aspect, healing processes cease, granulations wither, and secretion of pus diminishes. Very soon the edges of the wound swell, and the skin becomes bright red. The swelling and redness extend together, so that the limits of a **cutaneous erysipelas** while it is spreading are

sharply defined by a raised, well-marked border. The hyperæmia is followed by exudation of fluid, which collects beneath the epidermis to form vesicles, or else, accumulating in larger quantities, results in the production of bullæ. The exudation is not limited to the skin, but extends also to the subcutaneous tissue, and when the latter is loose, as in the eyelids and scrotum, the effused fluid may cause much swelling. Very shortly after the first symptoms of erysipelas, the lymphatic glands in the neighbourhood become inflamed and swollen, and soon afterwards, the lymphatics between them and the wound are marked out as tender and red lines. As the erysipelas spreads at the edges, it fades in the centre, and, when it ceases to spread, the raised, defined margin is lost, and the redness fades gradually into the surrounding tissues. It is not usual for cutaneous erysipelas to terminate in suppuration, but this may occur. After the redness begins to fade, the epidermis of the affected area quickly desquamates. The symptoms of fever are always well marked, but the amount of constitutional disturbance depends greatly on the condition of the patient's health.

In **phlegmonous erysipelas** the inflammation is not confined to the true skin, but extends more deeply, and involves the subcutaneous tissues. The redness of the skin is not so bright as in the cutaneous form, but the swelling is greater. The exudation contains much more of the fibrin-forming elements of the blood, and as a consequence causes great induration and brawny thickening; the inflammation is always very acute, and exudation most rapid. On account of the rapidity with which exudation takes place, the inflamed parts soon become very tense and shiny, their vessels are compressed, and they "slough" from interference with their nutrition. Almost all cases of phlegmonous erysipelas result in suppuration, and, after a time, the brawny thickening gives place to a softer and boggy feel,

which indicates the liquefaction of both inflamed tissues and inflammatory products alike. At this stage the epidermis frequently peels, and, especially when no treatment is adopted, large areas of skin die, together with portions of the subjacent areolar tissue. If the erysipelas now subsides, the dead tissue will be cast off as a slough, and an ulcerating surface will be exposed. In bad cases the sloughing process involves tendons, muscles, and vessels, and may leave a limb which is permanently damaged, or useless. Constitutional symptoms are much more marked in phlegmonous than in cutaneous erysipelas. The temperature frequently rises to 105°, or higher, and delirium is common. One of the most frequent complications is bronchitis with congestion of the lungs, or broncho-pneumonia.

Cellulitis differs but little from phlegmonous erysipelas. In it, however, the stress of the inflammation falls primarily on the cellular tissue, and only secondarily on the skin. As a result of this, redness is not so marked, and is usually preceded by swelling. Inflammation of the lymphatic vessels and glands is common, and suppuration and sloughing occur as in the cellulo-cutaneous form.

If a patient dies of any of the varieties of erysipelas, a post-mortem examination frequently reveals but little. The most common morbid condition is great congestion and œdema of the lungs, often combined with broncho-pneumonia and pus in the smaller tubes. Occasionally pleuritic effusion is found, and, when the head has been the seat of the inflammation, there may be diffuse meningitis. The abdominal viscera may be congested, and the blood more fluid than natural.

Causes of erysipelas.—It is probable that extreme plethora predisposes to erysipelas, and there can be little doubt that some individuals are, without apparent cause, specially prone to be attacked. The disease appears to be induced by chronic nephritis

rather than by affections of the other viscera, and in those fatal cases which I have examined after death I have almost always found catarrhal or interstitial inflammation of the kidneys. The accumulation of large numbers of suppurating wounds in a building, and exposure to bad smells or to draughts of cold air, act as exciting causes, whilst the retention of inflammatory products in a wound is always fraught with danger of erysipelas.

Recent experiments have made it almost certain that micro-organisms play a most important part in the causation of this disease, and the undoubted influence of such causes as have just been mentioned in no way tends to disprove the influence of organisms, for it is probable that the latter are only capable of causing trouble when under circumstances that are favourable for their growth and development.

It has been shown that in erysipelas the lymphatics of the skin are filled with micrococci, and the disease has been readily transmitted to other animals by inoculation either of fluid containing these organisms, or else of the micrococci themselves after many cultivations carried on in indifferent media. These experiments have been made on man as well as on animals, and in almost every case typical erysipelas followed inoculation. From the rapid extension of the micrococci along the lymphatics, erysipelas has been called "infective capillary lymphangitis."

CHAPTER X.

TETANUS.

TETANUS is a disease which usually follows an injury, and is characterized by tonic and clonic spasms of various muscles.

The injuries which are most frequently followed by tetanus are lacerated wounds of the hands and feet, but it may well be doubted whether this frequency is out of proportion to the exposure, and consequent liability, of such parts to sustain hurts. Tetanus rarely occurs within the first twenty-four hours after injury, and its onset may be postponed for several weeks. The wound very frequently is, or has been, in a sloughy and unhealthy state, but occasionally it is already healed when the symptoms appear.

The first complaint is generally that the neck feels stiff, as if from exposure to cold, and the movements of the jaws are soon impaired. After a time, swallowing causes spasm of the muscles of deglutition, and the jaws become clenched. Tonic spasm of other muscles ensues, and the abdominal walls consequently become hard and resistant. In many cases the muscles of the back are in a condition of tonic spasm, and the patient is bent backward into a position of opisthotonos. In addition to the tonic contractions, the patient is liable to be seized with sudden and violent clonic spasms, which affect the whole muscular system, and in the case of the diaphragm give rise to severe "girdle" pains. Constipation is common, and retention

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The injuries which are most frequently followed by tetanus are lacerated wounds of the hands and feet, but it may well be doubted whether this frequency is out of proportion to the exposure, and consequent liability, of such parts to sustain hurts. Tetanus rarely occurs within the first twenty-four hours after injury, and its onset may be postponed for several weeks. The wound very frequently is, or has been, in a sloughy and unhealthy state, but occasionally it is already healed when the symptoms appear.

The first complaint is generally that the neck feels stiff, as if from exposure to cold, and the movements of the jaws are soon impaired. After a time, swallowing causes spasm of the muscles of deglutition, and the jaws become clenched. Tonic spasm of other muscles ensues, and the abdominal walls consequently become hard and resistant. In many cases the muscles of the back are in a condition of tonic spasm, and the patient is bent backward into a position of opisthotonos. In addition to the tonic contractions, the patient is liable to be seized with sudden and violent clonic spasms, which affect the whole muscular system, and in the case of the diaphragm give rise to severe "girdle" pains. Constipation is common, and retention

of urine may occur. The mind remains clear throughout. The act of deglutition becomes impossible after a time, and any attempt to swallow excites spasm. Death may result from exhaustion, but is more frequently due to spasmodic closure of the glottis or to prolonged spasm of the muscles of respiration. The temperature frequently presents no material change, but occasionally it rises as high as 107° or 108°, and in such cases not infrequently continues to ascend after death.

Post-mortem examination rarely reveals any abnormal conditions. The viscera are usually quite healthy, but some of the muscles may be found to have been torn by the violence of their own contractions. The brain and spinal cord are quite normal to the naked eye, and, although inflammation of nerves in the neighbourhood of the wound has been described, it is certainly so rarely seen that its occurrence must be regarded as problematical, and its importance more than doubtful.

Causes of tetanus.—There are two chief theories as to the pathology of tetanus. One is that it results from some abnormal condition of the peripheral nerves at the seat of injury, which either directly extends to the spinal cord, or else reflexly excites general spasm. The other theory attributes the symptoms to the formation in the wound of some toxic material, which, being absorbed, acts directly upon the nervous system.

In support of the former theory it is stated—

That wounds of nerves may be found in cases of tetanus.

That inflammation of nerve trunks or branches is occasionally seen.

That section of nerves leading from the seat of injury has promoted cure in some instances.

That lesions of the spinal cord have been discovered on microscopical examination.

Against these it may be urged—first, that in wounds of nerve-trunks, and in operations of suture

and of stretching of the same, tetanus is almost never seen, whilst the argument that the disease is due to division of small filaments is absurd, for some filaments are necessarily divided in every wound, and therefore the demonstration of a wounded twig in a case of tetanus can have no importance.

Second, in the vast majority of cases, inflammation of nerve-trunks is certainly not present, and not more than half a dozen instances have been credibly described at any time. On the other hand, the symptoms of neuritis are never present in cases of tetanus, and no case of genuine neuritis has ever been known to give rise to this disease.

Third, in only ten cases has recovery followed on the operation of nerve section. In most of these the patients were treated vigorously with many and various drugs of known effect in tetanus, and usually the spasms did not pass away till several days after the operation.

Fourth, the lesions described in the spinal cord are equally compatible with the theory of a toxic agent acting on the spinal medulla, and the lesions themselves are such as to make it doubtful whether they were not the result rather of post-mortem than of pathological change. These lesions, which include destruction of ganglion-cells and the formation of distinct cavities in the nervous tissue, could not have occurred without inducing a paralysis which would have been more or less permanent had the patient recovered. It is, however, a clinical fact that paralysis never follows tetanus, and the importance of the lesions alluded to appears more than doubtful. In by far the larger number of cases, moreover, the cord is perfectly healthy—a fact which I have had frequent opportunities of observing.

Theoretically, also, the idea of peripheral irritation causing the spasms is most difficult to accept. For, even supposing that a cause of peripheral irritation were demonstrated, the movements which would

reflexly result would be first noticed in the injured limb, whereas it is the muscles of the neck and jaws which are the first implicated.

Again, if the cause were a peripheral one, the division of the nerves would provide a certain cure, whereas not only is this not the case, but even amputation usually gives no better result. It is idle to say that, the spasms having been once started, the removal of the exciting cause fails to effect a cure because the removal comes too late. Such a theory has no sound physiological basis.

The following are the chief arguments in favour of the toxic origin of tetanus:—

First, the occasional, but undoubted, idiopathic origin of some cases shows that local injuries are not essential for its production.

Second, the extreme prevalence of tetanus in certain localities would lead to the conclusion that it is independent of the injury of any special tissue, and would place it partly on a level with other endemic diseases which are certainly constitutional, such as malarial fevers, &c.

Third, the fact that coloured races are more susceptible to the disease than are Europeans renders it probable that the former afford a better soil for the germination or action of the toxic agent.

Fourth, the occasional occurrence of epidemics of tetanus in certain hospitals or localities establishes a similarity between it and the various fevers which follow wounds.

Fifth, there is a great similarity between tetanus on the one hand and hydrophobia and strychnia poisoning on the other.

Sixth, although inoculation of the blood of infected animals has failed to produce the disease, it is now claimed that it has been produced by inoculating material from the wound of a patient suffering from tetanus.

CHAPTER XI.

GANGRENE.

The term gangrene is equivalent to death, but is generally applied to death of large portions of the body, and not to that of small pieces of skin or cellular tissue. The death of these is spoken of as taking place by the process of "sloughing," and the dead portions of tissue are called "sloughs." In ulcers, as already described, death is "molecular," and the dead particles are too small to be recognizable by the naked eye. Gangrene is most usually due to interference with the circulation. If the supply of arterial blood be alone arrested, the tissues will not only die, but, being deprived of all fluid, will rapidly shrivel and dry up. In consequence of this, gangrene resulting from arterial obstruction is usually classified under the head of **dry gangrene.**

If the venous or capillary circulation is also interfered with, the dead parts will retain fluid in varying amount, and, remaining moist and succulent, are said to be in a condition of **moist gangrene.**

In other cases the death of the parts is the result of the action of some poisonous, and usually septic, matter introduced from without, and hence gangrene from this cause is classified under the head of **septic gangrene.**

In addition to these causes gangrene may result from

the action of some chemical agent such as strong nitric or sulphuric acid or caustic alkali.

DRY GANGRENE.

Dry gangrene is caused, as we have already said, by stoppage of the supply of arterial blood; it may be induced in various ways. In perfectly healthy people with healthy vessels it may be caused by any **injury to the main arterial trunks,** *e.g.*, subcutaneous laceration, pressure by a fragment of a fractured bone, the application of a ligature, &c., as well as by the lodgment of an embolus in some vessel too small to admit of its transit. In a very large number of patients who meet with such accidents the collateral circulation is quite sufficient to supply the peripheral parts with blood, but in others this is not so, and gangrene results. In such cases the patient usually suffers at first from severe pain of a burning character, pulsation ceases in the vessels below the seat of obstruction, and the limb becomes anæsthetic, cold, and pale. The onset of the symptoms is sudden, the pulsation in the occluded vessel can be felt to stop at the point of obstruction, and in this situation there is frequently some tenderness. In most cases the extent of the gangrene declares itself within forty-eight hours, and after this time it ceases to spread. If, however, the other vessels of the limb are diseased, the gangrene is not so rapidly defined.

As the limb dies, the colour changes from a dead-white to a bluish tinge, and then, if left long enough, gradually assumes a dull-red, greenish, or blackish hue. The skin shrinks into folds, and the epidermis becomes dry and horny. Finally, the gangrenous part is completely mummified, and in this state may easily be preserved for many years after removal from the body. Such complete mummification is rare, and more usually certain parts of the dead limb are succulent and decomposing.

dryness and blackness of the gangrenous part are
narked at the periphery, and where the dead skin
he living the former is of a dull-red colour, and
ratively moist. If the gangrenous part be left
tact with the living tissues, the latter soon show
ce of inflammation. A bright red line appears at
nction of the living with the dead; exudation
ammatory products proceeds with rapidity, pus
ned, and ulceration commences. In this way
ad parts are separated from the living by what
ımonly called the **"line of demarcation."**
ine, as will be seen, is the result of a process of
tion by which those living tissues which are in
:t with the dead parts are destroyed, and so
ted from the latter. The ulcerative process,
t has begun, progresses so long as the dead part
contact with, and so produces irritation of, the

In this way a gangrenous portion of a limb
ɔe completely separated and cast off, though
ı result will necessarily occupy much time if
s any bone involved. After separation has been
eted, the granulating surface which is left will
ke any other ulcer.

ıile gangrene is a variety of dry gangrene
lent upon disease of the peripheral arteries. In
ɔople the vessels are frequently the seat of
ma, or of primary calcareous degeneration. As
t of either of these morbid conditions, the arterial
become very tough, rigid, and inelastic, and in
:tion as they become so altered they are incapa-
l for the proper performance of their functions
riers of blood. The peripheral parts are con-
ıtly not properly nourished, and in some cases
ɔficiency in the blood-stream is aggravated by
ɔtting of the blood on the roughened vessel-wall,
ıe occlusion of the artery by thrombosis. These
ɔs are most commonly met with in the arteries
ɔ lower extremity, and thus senile gangrene

occurs most frequently in the foot and leg. In many patients with senile gangrene, the heart also is fatty and the general health feeble.

The limb of a person whose vessels are thus diseased is usually cold, and is liable to become readily numbed from exposure, or if subjected to compression of any kind; the arteries themselves may be felt as hard, rigid, and tortuous cords. If a toe of this ill-nourished limb be in any way injured, the slightest inflammation may produce an extensive stasis of the feeble blood-stream, and may thus completely deprive the parts of blood. Gangrene of the injured toe will now ensue, and the tissue in contact with it becomes in its turn the seat of inflammation, which again induces stasis and gangrene. The fact is that the vitality of the tissues is so low that they are unable to withstand the slightest interference with their nutrition, and the gangrene, having once started, will continue to extend till its progress is arrested by meeting with some tissue in which inflammation may progress to ulceration, and to separation of the living from the dead part by the formation of a "line of demarcation."

In some cases the gangrene is of the dry variety throughout, but most frequently the inflammation which precedes it in its course up the limb results in the exudation of a certain amount of fluid, and until this has been dried off the dead tissues remain moist. The gangrenous part is thus always most dry at its periphery, where it has been longest dead.

In many cases, after a line of demarcation has commenced to form, gangrene again begins to extend, an event which means that the parts reached by the gangrene are not sufficiently well nourished to withstand the call made upon their vital resources by the inflammatory process. Considering, therefore, that the parts about any line of demarcation are, so to say, only just alive, it is at once evident that any additional injury inflicted upon them, such as the cutting of a flap for an amputation, will be the cause of a further

ion of the gangrene. The appearance of the ssues and the mode of formation of the line of ation differ in no material respect from the processes already described in dealing with bject of gangrene from embolism and from

ents who are the subjects of senile gangrene are r in a very feeble state of health, and in many he pain, want of sleep, and absorption of septic ts from the decomposing tissues cause a fatal ation before the gangrenous process ceases. occasionally results from pulmonary embolism.

betic gangrene.—Persons who are suffering liabetes are liable to be attacked by a form of ne which resembles in many respects senile gan- although the dead parts do not shrivel and dry he latter, but, on the contrary, are often moist ecomposing. Diabetic gangrene is frequently l by some trifling injury, and spreads slowly up fected limb. Its course is perhaps more rapid is that of senile gangrene, and it evinces very tendency to limit itself by the formation of a f demarcation. The sole of the foot is the nest place in which diabetic gangrene com- s, and in some cases a "perforating ulcer" is ginning of the disease.

opathic symmetrical gangrene is the term d to certain cases of dry gangrene occurring at any evident cause, and usually, but not s, affecting parts symmetrically placed.

patients are generally young adults or children. arts affected are the fingers and toes, and more other portions which are exposed, such as the nd the nose. Very commonly there is a history or some time previous to the appearance of the ene, the extremities have been numbed and with enfeebled circulation and a tendency to tion of chilblains. Death commences at the ne periphery, and extends upwards. One or

several digits may die, and more rarely the gangrene extends to the whole hand or foot. In all cases the dead parts are extremely dry and mummified. Prognosis is good as far as life is concerned. The dead parts are separated in the usual way, and surprisingly good stumps are formed. The real cause of the gangrene is yet obscure. It is probably of neurotic origin, and in some cases at least is the result of peripheral neuritis.

Gangrene from frost-bite.—Parts which are frozen for a sufficient length of time do not recover their vitality on the removal of the cause. The result of exposure to extreme cold is a contraction of the arteries, which, if excessive and long continued, deprives the peripheral structures of their blood-supply to such an extent that they die and shrivel in exactly the same way as when a large vessel is occluded by a ligature or an embolus. If placed in a warmer atmosphere, blood cannot return to the frozen tissues, for the vessels as well as their surroundings are gangrenous. In such cases the dead part is shrivelled and mummified, and is in a condition of typical dry gangrene.

In other cases, where the deprivation of blood has not lasted so long, it has been noticed that if the part is suddenly placed in a warmer atmosphere, and blood is encouraged to return with great rapidity and in large quantities, gangrene will ensue with much greater certainty than if the frozen tissues are only slowly restored to their natural temperature. In such cases the gangrene is of the moist variety, and is preceded by much exudation and other signs of inflammation.

It is probable that the explanation of this variety of gangrene from exposure to cold is to be found in the behaviour of vessels which have been for some time deprived of their blood-stream. It has been shown in the chapter on Inflammation that the result of such deprivation is that, on the re-admission of blood, the phenomena of inflammation, with rapid exudation,

immediately ensue. The peripheral parts, already almost dead, cannot survive any further interference, and accordingly die. The moisture of the gangrenous tissues is the result of the exudation which has immediately preceded their death.

Gangrene from ergotism.—A very brief mention of this variety of dry gangrene is all that is necessary in the present work. The effect of ergot-poisoning is a contraction of the small arterioles, which, when long continued, may result in gangrene of the peripheral parts. It is very rarely met with in this country, where rye-bread is but little used as an article of diet.

MOIST GANGRENE.

In moist gangrene, the dead part, instead of drying and becoming mummified, remains moist and succulent. Unlike dry gangrene, the dead tissues quickly decompose, for moisture is a necessary factor in rapid decomposition, and is here abundantly supplied.

Moist gangrene occurs in its most typical form after ligature of the main artery and vein of a limb, and may also result from complete constriction, or from the extensive laceration and crushing of a limb which often result from accidents of various kinds. Being deprived of their arterial blood, the tissues perish, and, the venous blood being retained and often widely extravasated, the dead parts do not become mummified. The gangrene is limited to the parts below the seat of injury, the skin becomes blue or livid in colour, and the epidermis, being raised in bullæ, subsequently peels, and exposes the deeper parts of the skin. The whole limb becomes cold, pulseless, and swollen, and, as decomposition advances, gases form and give rise to emphysematous crackling. The deeper structures feel sodden and œdematous, their elasticity is lost, and they retain the imprint of a finger for some minutes. The living tissues above the occluded vessels quickly inflame, ulcerate, and

form a line of demarcation, but, on account of the decomposition and the rapidity with which the gangrene spreads, the absorption of septic material and a fatal termination are much more frequent in cases of moist than of dry gangrene.

Gangrene from acute inflammation. — In many cases of injury the deeper parts are extensively torn, although but a slight skin-wound has been inflicted. The result of this is that, if acute inflammation supervenes, the inflammatory products are retained, and by their presence interfere with the circulation in the injured limb. The more rapid the inflammatory exudation, and the more tense the structures beneath which the effusion occurs, the greater is the interference with the circulation, and the greater is the probability that death of the inflamed structures will ensue. The gangrene in such cases is necessarily of the moist variety, and, although it follows most frequently after injuries such as have been mentioned, it may occur in connection with acute inflammation and extreme tension excited by any cause, *e.g.*, in phlegmonous erysipelas. It is evident that if exit be given to the pent-up fluid by free incisions the cause of the gangrene will be removed.

SEPTIC GANGRENE.

Septic gangrene is quite independent of injuries to the main arteries or veins. It is probably the result of the local absorption of some septic material formed in a wound.

Acute spreading traumatic gangrene.—This, which is the best known of the varieties of septic gangrene, is especially distinguished, from the other forms of gangrene of which we have been speaking, by its tendency to spread. Supposing that a heavy cart-wheel has passed over a man's leg, and that all the vessels have been extensively lacerated, if simple moist gangrene results it will certainly be limited to the parts below the seat of injury; in spreading gangrene, on

the contrary, the parts above are just as likely to suffer as those below.

The patients in whom this form of gangrene occurs are usually adults, and may be either healthy or unhealthy. The gangrene may follow any injury, but is perhaps most commonly met with after compound fractures. It commences within a day or two of the accident, and is first noticed, not at the peripheral parts, as in gangrene due to injury of vessels, but **at the edges of the wound.** Here the skin becomes dark red, and then green or black. The skin in the neighbourhood assumes a dark-red hue, and the whole limb rapidly swells, and becomes extremely tense and œdematous from the presence of exuded fluid. Very quickly indeed the exudation is followed by decomposition, the epidermis peels, and the soft tissues beneath become emphysematous from the presence of the gases which result from decomposition. The gangrene progresses with such rapidity that within forty-eight hours from its commencement it may have spread over the whole limb and extended to the trunk. Unlike other forms of gangrene, it knows no limits, and **no line of demarcation** forms to arrest its progress. Unless the affected limb be early removed by amputation, death ensues with certainty, the patient sinking into an asthenic condition, and dying without any evidence of general septicæmia. The temperature is never raised to any great extent in typical cases, and may be sub-normal.

Phagedæna and hospital gangrene.—The term phagedæna is applied to a very rapidly extending and destructive form of ulceration, which is now most commonly seen in connection with venereal sores. Hospital gangrene, or "sloughing phagedæna," is so closely allied to phagedæna itself that the two diseases fade into one another; but, as the alternative name for hospital gangrene suggests, there is, in addition to rapidly extending ulceration or molecular death, more or less sloughing and death of the tissues *en masse*.

This form of gangrene, though formerly of common occurrence in crowded hospitals, is now but rarely seen.

Both hospital gangrene and phagedæna occur independently of interference with the blood-stream, and are each the result of the action of some specific poison, which is either formed in, or inoculated upon, a wounded surface. Both forms of disease are contagious, but hospital gangrene much more so than simple phagedæna.

A phagedænic ulcer has the following appearance:—The shape is irregular and ragged; the base is greyish and often sloughy; the discharge is scanty and thin; the edges are sharply cut, and show no sign of healing; the skin immediately around is of a dull-red hue. The ulcer is liable to extend indefinitely, but does not often advance to the destruction of such a large amount of tissue as is common in the case of hospital gangrene. The specific poison which is the cause, and the ulcerated surface which is inoculated with it, must be destroyed before a healthy action can be expected. Formerly, strong caustics were the only remedies employed, but of late years it has been shown that, in the phagedæna which affects venereal sores, at any rate, long-continued soaking in water produces all the beneficial effects of the caustic treatment.

Noma vulvæ.—This is a form of phagedæna which affects the external genitals of young children, and is usually seen in connection with dirt and ill-health, though frequently following measles. The appearance of the ulcer does not differ materially from that described above as typical of phagedæna. The general health is often seriously affected, and death not uncommonly results.

Cancrum oris.—This is a form of ulceration with sloughing peculiar to childhood, and is most usually met with before the age of five. The ulceration commences in the cheek or gums, and more rarely in the sockets of the teeth. In bad cases large portions of the cheek may be completely destroyed, and, the ulcera-

on extending to the jaws, necrosis of the bones and struction of the teeth ensue. The disease is very equently fatal, and septic broncho-pneumonia may mplicate it. Cancrum oris is probably the result of e action of some poison, and the object of treatment to destroy the contaminated tissues. This is usually ne by the aid of strong caustics.

CHAPTER XII.

BOIL, CARBUNCLE, AND MALIGNANT PUSTULE.

BOIL.

A BOIL is a circumscribed inflammation of the skin and cellular tissue, resulting in the death of the more central parts, and the formation of a slough. This sloughing is accompanied by suppuration of the parts immediately around the dead tissue, and the formation of a pustule which, opening on the surface, permits the discharge of the central slough or core.

Boils are the result of some disordered state of the constitution, and may be induced either by excessive feeding or by an insufficient amount of nourishment. Sudden changes of diet appear to be a common cause. Boils are more frequent in men than in women, and are most usually situated on the posterior surface of the body; the back of the neck and of the shoulders, and the gluteal regions, are their most common sites. Any local irritation may determine the situation of a boil in a person whose general health is in a condition favourable for its development.

CARBUNCLE.

A carbuncle is a specific localized inflammation of the skin and cellular tissue. It is characterized by considerable exudation into the inflamed area, with sloughing of the tissues involved, and formation of numerous pustules. The sloughs are separated from

the surrounding parts by suppuration, and, when loosened by this process, are cast off. A carbuncle differs from a boil in the following points:—It is usually single, is much more raised from the surface, and of much greater size. It frequently implicates the deep fascia, and discharges pus through numerous apertures.

Carbuncle is predisposed to by a condition either of plethora or debility, and not infrequently complicates diabetes. The patients in whom it occurs are usually men over middle age. Its most common sites are the nape of the neck and the shoulders. It more frequently produces a fatal termination than does a boil, and death may result either from general asthenia or from absorption of septic material and blood-poisoning.

Malignant facial carbuncle occurs, as its name implies, on the face. It affects people of all ages, but most frequently young adults, and is of decidedly rare occurrence.

Its most usual site is the lip, where it commences as a pimple, and thence extends to the cheek. Its structure is the same as that of carbuncle in other situations, but it is occasionally associated with a widespread thrombosis and suppurative phlebitis of the facial and ophthalmic veins, and with a general cellulitis of the face and orbits. In consequence, the whole face becomes greatly swollen, of a dusky red or purple colour, and the eyeballs may protrude.

The usual termination of a facial carbuncle is death, and this is most commonly due to pyæmia. It is probable that, in former years, some cases at least of "malignant pustule" have been mistaken for facial carbuncle.

MALIGNANT PUSTULE, CHARBON, OR ANTHRAX.

Certain herbivorous animals are liable to suffer from a disease which is variously known as "splenic

fever," "joint murrain," "black quarter," &c., and is caused by the presence of a micro-organism called the "bacillus anthracis." The bacilli are found in the tissues of the diseased animal as rod-shaped organisms, and may be cultivated so as to grow into long filaments containing numerous spores. They are very difficult to kill. The mode of infection of diseased animals is yet doubtful; it is probable that the organisms can enter either by the alimentary tract or else through wounds on the surface caused by bites of insects, &c.

Malignant pustule is a disease produced in man by inoculation with the bacillus anthracis, and is generally due to contamination of some slight excoriation by contact with the hides, wool, or hair of diseased animals. It is consequently most commonly seen on the face, neck, or hands of wool-sorters, tanners, and others who are in the habit of handling portions of infected animals.

Malignant pustule commences as a small, red, irritable pimple. After twelve to twenty hours a vesicle forms and bursts, exposing the deeper layers of the skin. Around this central spot a ring of vesicles now forms, and the contiguous skin quickly assumes a dull-red hue. The central spot dries and becomes black and shrivelled, the tissues outside the ring of vesicles swell, and become indurated and brawny, the vesicles burst and expose more black and shrivelled skin, and the central slough thus increases in size whilst fresh crops of vesicles are produced. The neighbouring lymphatic glands are often swollen. Symptoms of constitutional affection are frequently severe, and death is a common result; on post-mortem examination, the tissues present appearances such as are found in cases of septicæmia. Occasionally spontaneous recovery occurs. An examination of the fluid in the vesicles will reveal the presence of numerous pathogenic bacilli, and the latter have

also been met with in the sputum, urine, sweat, and blood.

The most typical points about a malignant pustule are the central dry slough, the ring of vesicles, the raised brawny induration, the absence of severe pain, and the total absence of suppuration.

CHAPTER XIII.

TUBERCLE AND SCROFULA.

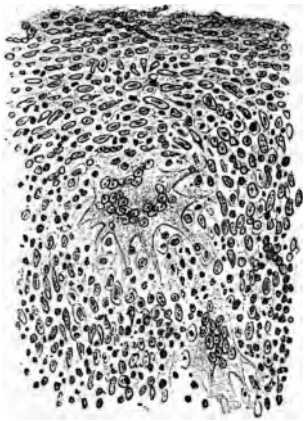
Both tubercle and scrofula are more fitly dealt with at length in works on general pathology than in one devoted solely to the surgical aspect of this subject. It is not purposed, therefore, to do more than indicate as briefly as possible the general meaning which will attach to these words when employed in future chapters.

A tubercle is an infective granuloma of inflammatory formation, and, according to the belief of most authorities, is dependent for its origin on the presence of a micro-organism—the tubercle bacillus. In its most typical form a tubercle appears to the naked eye as a minute, grey, semi-transparent granule, the size of a mustard seed—a "grey tubercle." As its size increases, the more central part of this granule becomes opaque, and is gradually transformed into a soft, fatty, or cheesy mass—a "caseous tubercle."

Microscopical examination of a grey tubercle shows that it consists of a collection of small clusters of cells, each cluster being complete in itself, and forming a so-called "elementary tubercle" or "primitive tubercle." The typical structure of each of these latter is—first: one or more central giant-cells about $\frac{1}{150}$ of an inch in diameter, with a granular protoplasmic stroma containing numerous nuclei, which show a tendency to be arranged in a ring around the circumference of the cell; the cell-body generally sends out processes

h join those from other cells in the neighbourhood. nd: around the giant-cell is a zone occupied by which are larger than leucocytes and have a clear ody; they are of connective-tissue origin, but their likeness to epithelial cells have been named thelioid." Third: the outer margin of this zone imperceptibly into a more or less dense mass of cytes, which in all cases form the outer zone of primitive tubercle, and in many instances make ie great bulk of the whole growth. All the cells ighout the primitive tubercle are embedded in a hoid reticulum of branched connective-tissue cells. whole tubercle is practically non-vascular, blood- ls not penetrating beyond its extreme margins.

FIG. 6.



Section of Tubercular Synovial Membrane, showing two giant-cells with numerous processes, and containing many nuclei.

tubercle **bacillus** is from .0015–.0035 mm. in h; it is usually straight, but sometimes slightly d; it is found in all parts of a tubercle, but ially in the giant-cells.

Such is the structure of a typical tubercle, but it would be erroneous to suppose that such is the structure of all, for the giant-cells may be absent, or, if present, may not possess any definite processes, the epithelioid cells may be very few and ill-developed, and the bacillus may not be discoverable. The small cell growth and the lymphoid reticulum or matrix are, however, constant.

An examination of a tubercle at a later stage shows that the central parts of the elementary tubercles are degenerating so as to form a fatty pulp, a result which is evidently due to the fact that in the growth of a tubercle no new blood-vessels are developed. In some specimens the whole of the growth may be found transformed into a caseous mass.

In any organ affected with tubercle there is a tendency for the disease to spread locally, and to set up in the tissues in which it occurs the processes which are common to all inflammations. On the other hand, an inflamed organ is itself more liable than a healthy one to become the seat of tubercular disease. And not only is tubercle locally infectious, it is constitutionally so as well, and thus in any given case there is a possibility of general dissemination, with production of tubercles in all parts of the body. In such cases of **general tuberculosis,** there is commonly some pyrexia, and the termination is usually fatal.

Scrofula is a constitutional condition in which there is a tendency to local chronic inflammations whose special characters are—that they persist long after their exciting cause has passed away; that they extend to neighbouring parts; that the cell exudation constantly tends to caseate and to form a fatty pulp, or else to break down into ill-formed and curdy pus; and that healthy reparative processes are conspicuous by their absence. It would appear that the tissues *of a scrofulous* individual are ill formed and of low

vitality, and that any inflammation once started in them is liable to persist on account of the inability of the tissue to initiate a healthy suppuration which might rid it of its disease, or a proper reparative process which might repair the original injury. In all scrofulous inflammations the adenoid or lymphatic tissues seem to be particularly implicated; thus, in the tonsils, pharynx, and intestines it is the lymphoid tissues which are specially diseased, and, although more difficult to demonstrate, it is yet tolerably certain that in the strumous diseases of bones and joints the same rule holds good.

An examination of a tissue in a state of strumous inflammation shows a considerable quantity of inflammatory new formation, with swelling and softening of the affected part; at a later stage there is much pulpy, friable matter, and finally the diseased tissue is found infiltrated with caseous material. There are no macroscopic or naked-eye tubercles as in tuberculosis. A microscopical examination shows the usual cell exudation met with in all inflammations, with little or no formation of fibrous tissue, and much fatty degeneration. In addition, in many instances, primitive tubercles with giant-cells and lymphoid reticulum are found, and are quite indistinguishable from the similar growths in the macroscopic tubercles already described. The tubercle bacillus also is to be seen in some instances.

The scrofulous constitution may be either congenital or acquired. Most usually it is the former, but there can be little doubt that insufficient food and bad hygienic conditions may produce it in an individual in whom no congenital taint has been apparent. The parents of scrofulous children are often themselves scrofulous, and in other cases have been the subjects of tubercular diseases; the children of consumptive patients are frequently strumous.

The connection between scrofula and

tubercle is a subject which has been much discussed, and even at the present time much difference of opinion exists. There can be little doubt that the diseased conditions are closely allied, but it is practically certain that the clinical course of those cases in which grey miliary tubercles are present differs very materially from that of the others, or scrofulous ones, in which there is simply a low form of chronic inflammation without the formation of such structures. The tendency to dissemination in the former is infinitely greater than in the latter, and is a practical point of some importance.

It must, however, be allowed that in their microscopical characters many scrofulous lesions are not to be distinguished from those which are truly tubercular, and it is contended by some that the diseases are of identical nature. In support of this conclusion, it is argued that tubercle has been produced in animals by inoculation with matter from a scrofulous inflammation, and that, on the other hand, scrofulous disorders have resulted from inoculation with tubercle. It has also been demonstrated that the tubercle bacillus is present in some at least of the scrofulous lesions, and those who consider that it is the cause of all true tubercle hold that its presence in scrofulous inflammations suffices to place the two processes under one classification. It is quite certain that some at least of the lesions of scrofula are of a truly tubercular nature, but it is by no means proved that all of them are; *e.g.*, the eczema of the head and face, the inflammation of the eyelids, the strumous ulcers of the cornea, have nothing tubercular about them. It must always be remembered that the general health of scrofulous children is at best feeble, that they are weakly and ill-nourished, with stomachs and intestines often out of order and unable to properly digest and assimilate the food they receive. Such patients are of course, independently of their scrofulous taint, ore liable than healthy children to such troubles as

frequently recurring eczema, chronic catarrhs, and many other affections which, although common in strumous subjects, are most likely more dependent on the general ill-health of the patient than on his strumous diathesis.

It is very probable that the formation of tubercles is in many cases secondary to an inflammation which originally was chronic simply because the tissue in which it commenced was badly nourished and lowly organized. Thus, the inflammation would in such a case be primary, and the formation of tubercle secondary. This actually happens in some cases of phthisis, where the original trouble is an attack of broncho-pneumonia or pleurisy, and the tubercle is subsequently developed in the structure which has been damaged by the inflammatory process. There can, indeed, be little doubt that the spread of tubercle depends to a great extent on the condition of the tissues of each individual. All persons are not equally predisposed to it, and all tissues in the same person are not equally liable to attack. It may well be that in certain scrofulous inflammations the development of tubercle at the seat of disease is not followed by general affection of the viscera because the latter are not in a sufficiently susceptible condition, whilst in other cases, where dissemination and formation of macroscopic tubercles are present, the conditions for spreading are more favourable.

Again, in those cases in which a tubercular disease of a particular organ runs its course unchecked until the death of the patient, and yet is limited throughout to that viscus—*e.g.*, the lungs—in which it started, it is certain that many other viscera must have been exposed to the infection and yet have escaped, a result which must depend upon their own power of resistance. It seems, indeed, the most simple explanation of scrofulous inflammations to attribute their occurrence to the same cause as that of tubercle, *i.e.*, the tubercle bacillus, and to explain the difference in

result by the greater powers of resistance of the tissues themselves.

MANIFESTATIONS OF SCROFULA.

The scrofulous constitution is supposed to show itself in the features and build of the subject. In the so-called "sanguine" variety the skin is thin and transparent-looking, the complexion is clear, the hair is fine and light-coloured, the eyelashes are long, the eyes are large and bright, the face is oval, the bones are small, the muscular development slight, and adipose tissue scanty. In the "phlegmatic" form the skin is thick and the complexion muddy, the lips and nose are thick and prominent, the hair is coarse and dark, the eyelashes are long, the eyes dark, the features are badly modelled, and the bones and limbs are clumsy and thick. In many cases the typical appearances are by no means so strongly marked as the above summary would indicate, and between such typical cases and those in which the patient merely exhibits the usual signs of weak and delicate health all varieties may be found.

Amongst the many ailments to which scrofulous patients are liable the following are some of the commonest. Further descriptions of the most important ones will be found in detail in the chapters devoted to special parts of the body, such as the bones, joints, &c.

The skin is frequently the seat of chronic eczematous inflammations, which are easily excited by the slightest causes, and are most common about the exposed parts, notably the head and face.

Ulcers also are of common occurrence. They are typically of irregular shape, but with a tendency to become circular. They are variable in size, and their base is either sloughy, smooth, and shiny, or covered by pale and flabby granulations of irregular size, but usually larger than natural. The pus secreted is scanty, shreddy, and watery. The edges are thin, ragged, and

undermined, and both they and the surrounding skin are often blue, cold, and congested. Chilblains are common in scrofulous subjects, and lichen and impetigo may also occur.

The disease of the skin which is most typical of scrofula is **lupus,** which must, indeed, be regarded as essentially a scrofulous lesion.

Lupus is most commonly seen on the face, and is specially liable to attack the nose; it usually commences in the young, and rarely begins after the age of five-and-twenty, although it may continue to *recur* at any age. Its earliest appearance is in the form of a small pimple, and in other cases there is a collection of papules or tubercles. The affected skin is redder than natural, and the epidermis soon peels off and exposes a raw, red surface, which slowly ulcerates. In some cases the edge of the lupoid ulcer is surrounded by a ring of small papules like that which preceded its formation, and by a constant breaking down of these growths the ulcer increases in size. The discharge from the ulcerated surface is watery pus, mixed with epithelial scales, and readily forms a scab, around the edge of which ulceration progresses.

As in other scrofulous lesions, the inflammatory products tend to degenerate, and the tissues around the edge of the ulcer become very soft and friable. The ulceration is slow, but may extend over wide areas and involve deep structures. Thus, the nose, eyelids, cheeks, and lips may be implicated, and the nasal cartilages and bones may be destroyed. Even if the morbid process has ceased, it is peculiarly liable to recur, and treatment of all kinds not infrequently fails to arrest its progress. If the ulcers heal, the scars are usually thin and badly formed, whilst cicatrization may progress in one part and the ulcer may extend in another; the scars, when formed, are very liable to again break down.

Microscopic examination of a lupus patch shows

chiefly cell exudation into the papillary layers of the true skin, with desquamation of the surface epithelium and enlargement of the inter-papillary epithelial processes. The sebaceous glands are larger than natural, and their cells are in a state of proliferation. The exudation around the hair-follicles generally causes the destruction of the hair. Tubercle bacilli are occasionally present, but are in any case extremely few and difficult to find.

The mucous membranes in scrofulous subjects are peculiarly liable to catarrh. Thus, such patients are more than others predisposed to "catch cold." The catarrh of the alimentary tract is made evident by the foul breath, furred tongue, and weak digestion. Stomatitis and discharges from the nose are of frequent occurrence, and enlargement of the tonsils, with or without catarrh of the middle ear, is one of the most common of all the lesions met with in struma. Phlyctenular ophthalmia and tinea tarsi occur in connection with the conjunctiva; from the vagina muco-purulent discharges are common, and the bladder may be irritable and unable to retain urine for any length of time.

The bones and joints are as liable as are the soft parts to scrofulous inflammations, but their diseases, as well as those of the **genito-urinary organs**, will be described more at length in the chapters on such subjects.

The lymphatic glands are specially liable to scrofulous inflammations, and it has been pointed out by Mr. Treves that the most frequent cause of their enlargement is "a lesion that implicates the adenoid tissues of a mucous membrane." The mucous membranes of the naso pharynx and of the intestinal and bronchial tracts are specially rich in adenoid tissue, and it has already been mentioned that catarrh of these surfaces is very common. So, therefore, is disease of those glands common into which the lymphatics of these parts empty. The glands of the neck, thorax,

and mesentery are infinitely more often diseased than are those of all other parts of the body, and it is quite unusual for glandular affection to follow strumous ulceration of the skin of the extremities or caries of bone.

The diseased glands become enlarged very slowly as a rule, but occasionally their growth is comparatively rapid ; they vary in size, and sometimes altogether subside; after an indefinite length of time they become adherent to the surrounding parts, and evidences of inflammation slowly develop. The skin becomes dull red and adherent; suppuration ensues, and the resulting abscess opens through an irregular ragged aperture, which is very slow to heal and leaves an ugly scar; suppuration does not occur in more than a small percentage of all cases. The pus in such abscesses is ill formed, curdy, and shreddy, and is mingled with caseous material. Very often these glandular swellings cease to grow, and remain stationary for many years; in such instances calcification may ensue, and the whole gland may be converted into a chalky mass.

On section, a strumous gland is softer than natural, and generally presents several masses of caseous material embedded in its substance; glands which have been long diseased may be completely converted into a caseous pulp, with which is mingled, in some cases, a certain amount of ill-formed pus.

Microscopical examination shows the changes common to all chronic inflammations. The cells in the gland multiply at certain places which appear to be foci of the scrofulous process, and at the same time that they multiply they often become larger and more translucent than natural; mingled with the cells is some fibrinous exudation. In the centre of each of the foci above mentioned fatty degeneration of the cellular elements soon ensues, caseous masses are

formed, and after a time true elementary tub with giant-cells and a lymphoid reticulum ap In some cases, where the influence of the scrof diathesis is less evident, there is a formatio fibrous tissue, though this is seldom a prom feature.

CHAPTER XIV.

SYPHILIS.

VENEREAL SORES

VENEREAL sores are of two kinds—(*a*) the non-infecting; (*b*) the infecting.

The **non-infecting sore** makes its appearance from two to five days after exposure to infection, and frequently several sores result from a single inoculation.

It commences as a pustule, which bursts and discharges its contents, leaving an ulcer. The latter is generally circular in shape, sometimes no larger than a split pea, but frequently extending over a considerable area of skin; the base is grey and sloughy, with marked absence of granulations; the edges are usually sharply cut—giving a punched-out appearance to the sore—but are sometimes ragged and undermined; the secretion is scanty, and consists of shreddy and watery pus. Ulcers such as these may occur on any part of the penis, but are most common on the glans and on the foreskin immediately behind the corona. In many cases the lymphatic glands in the groin inflame and suppurate, the pus which is formed in them being capable of producing by inoculation sores similar to the original ulcer. As a rule, non-infecting sores are not indurated, and are therefore spoken of as "soft sores;" sometimes, however, they do become indurated, especially when they extend into the areolar tissue beneath the skin. Venereal sores of all

kinds are more liable than are most ulcers to take on a phagedænic action, and by this process considerable portions of the penis may be destroyed. Soft sores do not cause any constitutional infection, and are therefore called non-infecting.

Infecting sores are the result of inoculation with syphilitic virus. An infecting sore never makes its appearance earlier than ten days after exposure to contagion, and most commonly does not show itself for about three weeks, whilst as long an interval as six or seven weeks may elapse between infection and the development of the sore. The infecting sore presents three chief varieties:—

(1) The epidermis may appear abraded or excoriated, and, peeling off in flakes, exposes a circumscribed patch of a livid purple colour. There is no ulceration and no induration.

(2) An indurated tubercle may form beneath the epidermis, and, the latter remaining intact, the surface of the sore is not excoriated and does not discharge.

(3) A definite raised nodule may develop in the substance of the skin. It is coin-shaped, being flattened on the surface, with circular margins, and a definite elevated edge; it is very hard, and feels like a piece of cartilage set in the skin. The surface is red, raw, and excoriated; it discharges a thin watery fluid, which contains much epithelial débris and a few leucocytes. An infecting sore such as this is a so-called "Hunterian chancre" or "hard sore."

Of these three forms of infecting sore, the second and the third are the most common, and the latter more so than the former. The most usual situation for all of them is the prepuce just behind the corona glandis. They are commonly single, but may be multiple. Any of these sores, if irritated by dirt, by friction of the clothes, or by other agencies, may suppurate, but none of them normally suppurate or form ulcers. The induration is the result of inflammatory exudation into the tissues, and in cases which are not

treated may persist as long as six or nine months, or even longer. In cases of infecting sores the lymphatic glands in the groin become enlarged and indurated. Often they are neither inflamed nor painful, but if the sore itself suppurates from exposure to irritation of any sort, then the glands in the groin may inflame and suppurate; if pus is formed in them it has no specific properties, and is not inoculable.

It must constantly be borne in mind that a patient may have exposed himself to the infection of both infecting and non-infecting sores, and in not a few cases both varieties of sores develop in the same patient.

The non-infecting and the infecting sores are now generally held to be the result of inoculation with different poisons. Thus, a soft sore will by inoculation always produce a soft sore, and an infecting sore will always produce a sore which is followed by constitutional symptoms. A non-infecting sore cannot produce an infecting one.

SECONDARY SYPHILIS.

Syphilis is a specific and contagious disease propagated by local contamination.

An infecting sore, such as already described, is the usual precursor of constitutional infection, but it must, however, be clearly understood that by the time this primary sore appears the system is already contaminated, and that excision of the chancre is therefore useless as a preventive measure. The sore itself may justly be considered as the first expression of the constitutional disease.

Further local evidences of constitutional infection generally appear at about the sixth week after the development of the primary sore, and are sometimes accompanied by slight continued pyrexia. These early manifestations of syphilis are liable to succeed one another for a space of about a year or eighteen months in untreated cases, and to this stage of the

disease the name of secondary syphilis has been applied. In typical cases, after apparent complete subsidence, further local lesions make their appearance, and to this stage the name of tertiary syphilis is given. It would, however, be a grave error to suppose that these two periods and their accompanying lesions are always clearly separated from one another. This is by no means the case, for lesions usually described as tertiary may supervene within the first twelve months after infection, and secondary symptoms may occur after several years. It is practically certain that the varying severity of the manifestations of constitutional syphilis is not in any way dependent upon any alteration in the character or dose of the original virus, but rather upon the constitution of the patient in whom the disease occurs. Thus I have seen extensive rupial ulceration with destruction of parts of the lips and cheeks occur in a woman within six months of infection by her husband, whilst the latter had himself only suffered from slight sore throat and a transient skin eruption. Again, there are some men who, although frequently exposed to contagion, never acquire the disease, whilst others are not protected, as are most, by one infection, but contract the disease afresh at some future time. In this respect syphilis merely resembles many other diseases, for there are plenty of cases in which persons are so susceptible to the infection of measles and scarlatina that they contract them as many as three or four times.

But although constitutional syphilis differs much in severity in different cases, there are certain local lesions which typically occur in the early or secondary stage of the disease, and although at first sight they appear to differ very widely from one another in their nature, such is not really the case, for in almost all of them the same pathological process is to be found. The typical lesion of secondary syphilis is **plastic inflammation.** The induration

of the infecting sore is due to the exudation of plastic lymph; and whether it be the testis or the eyeball, the arterial system or the skin, the periosteum or the lymphatic glands, which is the seat of early syphilitic disease, in each and all alike there is an exudation of inflammatory products, a tendency to the formation of young fibrous tissue, and a consequent thickening of the diseased part. In addition to these plastic exudations, ulceration occurs with considerable frequency in some tissues, but it should again be remembered that the constitution of the patient himself has much to do with the determination of suppuration.

It is not possible to deal at all exhaustively with the lesions of constitutional syphilis, and it is not proposed to do more than describe very briefly those which are the most important.

The cutaneous system suffers very constantly in syphilis, and is often the seat of the most early evidences of constitutional infection. The eruptions that occur are various. One of the commonest is a roseola, which commences on the abdomen and thorax, extends afterwards to other parts of the body, and usually fades without treatment in the course of a few weeks. In such an eruption there are numerous rose-coloured, circular spots, which are sometimes so closely set that there appears to be but little unaltered skin, while in other cases they are very few and faint in colour. The spots are not at all raised, and readily disappear on pressure.

Mingled with this roseola there is frequently seen a lichenous eruption, consisting of numerous small papillæ of a copper colour, which terminate either by desquamation or resolution.

At a later period tubercles may be developed. They differ from the papillæ of lichen chiefly in their size, and, like the latter, are the result of plastic exudation into the papillary layer of the skin. The epithelium covering these tubercles almost always

desquamates, and comes away in very fine, powdery scales. After desquamation, the tubercular eruption assumes a dull-red or copper colour. In some patients the tubercles ulcerate, in others they do not, but in either case permanent pigmented scars are frequently left. The forehead—and face in general—is one of the favourite sites of these tubercles, the resulting pigmented scars being very unsightly.

Another rash, which is one of the earliest to appear as well as one of the latest to persist, is the squamous syphilide, to which the name of syphilitic psoriasis is often applied. The most common sites of the eruption are again the abdomen and thorax, and the flexor aspects of the arms and forearms. The rash consists of circular spots, slightly raised from the surface, sometimes white from the presence of epithelial débris, and, when the latter has been cast off, of a dark-reddish tint. The palms of the hands and the soles of the feet are affected with comparative frequency, and in these situations the eruption is most persistent and intractable. The squamous syphilide can generally be readily diagnosed from simple psoriasis, for there is often some other evidence of syphilis; it does not occur, as the simple form does frequently, in children; the elbows and knees, common sites for psoriasis, are usually not implicated; the rash is common on the flexor surfaces and on the palms and soles; it is sometimes mixed with other of the syphilitic eruptions already described, and in its later stages assumes the typical coppery colour.

Pustular eruptions are not common in secondary syphilis, but one form is met with sufficiently often to deserve mention. This is the syphilitic ecthyma, in which pustules form in the skin and come to the surface and discharge their contents without there being at any time marked pain or surrounding inflammation. After the pustule has burst, a scab forms of a circular shape and considerable thickness; it is very adherent, and often persists for a long time. If

removed, a circular sloughy ulcer is exposed, which, when not treated, again becomes scabbed over, and shows but little tendency to heal. When cicatrization does occur, a circular and permanent scar remains.

Such is a very brief description of the most common forms of skin eruption met with in secondary syphilis, but, although they have been treated of separately, it should be borne in mind that one of the chief characteristics of syphilitic rashes is that they differ in different parts of the body, and in any individual case of syphilis several of the above varieties may be present at one and the same time.

Most of the eruptions are liable to assume the copper tint after lasting for some weeks, and scars, if formed, are specially liable to be pigmented.

The cutaneous appendages—the hair and nails—suffer together with the skin itself. The hairs become loosened in their sheaths by an extension to them of some of the inflammatory processes in progress in the skin, and are shed in great numbers. In some cases the head becomes completely bald, and the hair of the face may share in the general destruction. In most cases, baldness is not permanent, and after a time the hair becomes as thick as before.

The nails are liable to be attacked by a low form of inflammation which extends to the matrix and causes much swelling and tenderness of the whole finger-end. The ensuing ulceration is most chronic and intractable, and generally continues until the nail has been removed by the surgeon, for, although it is loosened by the ulceration, it is comparatively seldom entirely separated.

The mucous surfaces.—At the same time that the eruptions appear on the skin, the mucous membranes are commonly the seat of syphilitic inflammations.

On **the anus,** at the junction of the mucous lining with the cutaneous surface, "mucous tubercles" develop. *These are warty growths* with broad bases

of attachment covered by a thin layer of epithelium, and moist from the constant watery discharge which exudes from them. They are commonly multiple, and, when excoriated or inflamed, give rise to considerable pain. They consist of young connective tissue, and vary in size from an ordinary cutaneous wart to a hazel-nut.

The lips are also liable to be attacked by similar growths, which seldom attain so great a size as do those around the anus. In addition, the lips are often cracked, fissured, and superficially ulcerated. **The gums** may be in a similar state.

The tonsils are ulcerated in almost every case of acquired syphilis. They become swollen and inflamed, and ulcers of circular shape with sharply cut edges penetrate deeply into their substance; the base of these ulcers is often sloughy. Mucous tubercles also may form on the tonsils.

The tongue is sometimes involved in the eruptions which occur on the cutaneous surfaces, and is specially liable to be attacked by the squamous syphilide. Superficial ulceration is common around its edges, but deep ulceration is rare.

The larynx may be simply inflamed, and its mucous membrane slightly swollen, or mucous tubercles and superficial ulceration, such as occur on the lips and tongue, may be present. It is to the diseased state of the larynx rather than to that of the tonsils that the hoarseness which so often occurs in secondary syphilis is to be attributed.

The nose is not often affected in early syphilis, but its mucous lining is occasionally inflamed at the same time that the lips and gums are attacked.

The eye.—The commonest affection of the eye in secondary syphilis is plastic iritis. This is accompanied by pain and aching, with more or less photophobia and lachrymation. An examination shows that the conjunctiva is hyper-vascular, and the iris is

surrounded by the deep zone of vessels which is the usual accompaniment of all forms of iritis. The aqueous humour is turbid from admixture with inflammatory products, and the colour of the iris is consequently blurred and altered in shade. The pupil is sluggish, often different in size from its fellow, and sometimes irregular. In the anterior chamber, on the margins of the pupil, and in the substance of the iris may be seen beads of lymph. If syphilitic iritis is allowed to run its course unchecked, the plastic effusion is liable to become organized, so that the pupil is either blocked by fibrous tissue, or, more frequently, the iris becomes adherent to the lens capsule on the one hand or to the cornea on the other. The formation of such adhesions is often followed by a very persistent form of chronic iritis, which sometimes results in a gradual extension of the inflammation to the ciliary processes and choroid.

The testes are often attacked by plastic inflammation; one or both glands may be involved. In this form of orchitis there is a general enlargement of the testis from effusion into it of plastic exudation, which tends to become organized into fibrous tissue, but which is generally in great part finally absorbed even in cases which are not subjected to treatment; on section, such a testis will appear more tough and fibrous than a normal organ. In these cases the inflammation commonly extends to the tunica vaginalis, and effusion of fluid into the cavity of the latter is of frequent occurrence. The epididymis is not usually implicated in the inflammatory process, and, except for slight œdema, the cord is also free. Such a testis is painless, and gives no trouble, except by its size. It is often as large as a hen's egg, smooth, heavy, oval, not tender, with marked absence of testicular sensation when subjected to pressure, and firm to the touch. In cases of long duration, the gland substance may be compressed by the contraction of the fibrous tissue,

and become atrophied. The organ thus passes into a condition of cirrhosis entirely analogous to that which is met with in the liver of drunkards.

The diseases of the **bones, joints,** and **arteries** are described in the chapters devoted to these subjects.

TERTIARY SYPHILIS.

The typical lesion of tertiary syphilis is the formation of **gummata,** but, in addition, there is a general tendency to suppurations in various parts of the body.

A **gumma** is an inflammatory new growth in which the cell exudation has a special tendency to degenerate and form gummy or caseous masses. The exudation at first is in no way distinguishable from that of a simple inflammation, and its initial tendency is to develop into young fibrous tissue. This development, however, is generally very imperfect, for the cell-growth is not sufficiently vascularized, and soon degenerates into a caseous pulp. The caseous material is always found in the central or oldest part of the gumma, and is surrounded by the ill-developed fibrous tissue just mentioned, whilst outside this again the cell exudation progresses, and causes a constant increase in the size of the swelling. Three zones are commonly described in a gumma—the outer or cellular, the middle or fibrous, and the central or caseous.

As a gumma increases in size it is accompanied by all the symptoms of chronic inflammation, and is often surrounded by much plastic exudation. When it comes to the surface and discharges its contents, a circular crater-like cavity is left, the edges of which are much undermined, and the base sloughy. If no treatment be adopted, healing is very slow, and a depressed scar always results. Gummata vary much in size, the average growth being not larger than a walnut, whilst swellings as large as or larger than an apple are sometimes seen. The commonest sites for gummata are the muscles and subcutaneous tissues,

but they occur also in the liver, kidneys, spleen, brain, spinal cord, tongue, bursæ, joints, and testes. In addition to the definite circular swellings to which the name of gumma should be limited, inflammations with a tendency to the same formation of caseous matter, but without the same circumscription or tendency to form globular masses, are common in tertiary syphilis, especially in connection with the osseous system. To such inflammations the epithet of "gummatous" is well applied.

Diseases of the skin and cellular tissue.—Ulcers of a peculiarly unhealthy and persistent nature are of frequent occurrence in tertiary syphilis. They may form in any part of the body, but are perhaps most common on the lower extremities. The base of such an ulcer is usually sloughy, and the pus secreted scanty and shreddy. The edges are sharply cut, and are often crescentic in shape; these ulcers sometimes attain a considerable size, and when occurring on the face may simulate lupus.

Rupia is a form of ulceration of the skin which is met with in syphilis alone. Each ulcer commences as a vesicle; this pustulates, its contents are discharged, and a scab forms. Beneath the scab ulceration progresses eccentrically, and fresh scabs are produced. In consequence of the constant increase in circumference of the ulcer, the more recent scabs are larger than the earlier ones, and a conical concretion is thus formed, the first and smallest scab being at the apex of the cone. If the scab is removed, an unhealthy, sloughy ulcer of circular shape, and about the size of a sixpence or a shilling, is exposed. When this has healed, a pigmented cicatrix remains. A score or two of such ulcers may be present at the same time in a single individual.

Diseases of the mucous surfaces.—The tongue may be the seat of gummatous growths or of deep ulceration. The former occur chiefly on the dorsum, and often near the tip. They vary in size

from a pea to a walnut, and, when their contents have discharged, a typical gummatous ulcer remains. The deep ulceration may affect the whole dorsum of the tongue, or a part only of one of the lateral margins. In the former case fissures form, and the whole surface becomes cracked and furrowed. In the latter, deep ulcers, with sharply cut edges and sloughy bases, develop on the sides of the tongue, chiefly towards its posterior part, and sometimes closely simulate epithelioma. Both these forms of ulceration are most persistent and intractable, and are, moreover, liable to frequent recurrences.

The larynx, like the tongue, is liable to be destroyed in part by ulceration. This very frequently commences in the epiglottis, and may completely destroy it. The ary-epiglottic folds are also commonly involved, and the destructive process may extend to the true vocal cords. In bad cases the cartilages of the larynx are attacked, and either ulcerate or necrose. In consequence of the very considerable formation of fibrous tissue which follows the ulceration, the glottis is sometimes stenosed, and dyspnœa results.

The alimentary tract as a whole is remarkably free from syphilitic disease, for although cases of ulceration of the small intestines have been recorded, they, as well as the œsophagus and stomach, usually escape. The rectum is not so fortunate, and extensive ulceration spreading up the gut from near the anus sometimes causes the formation of numerous fistulæ, with thickening of the gut and resulting stricture. In some cases a fatal result ensues either from long-continued suppuration or from peritonitis.

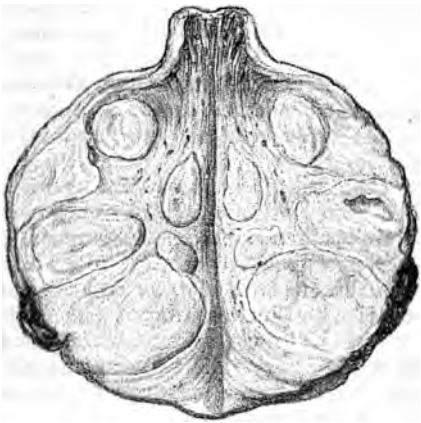
Visceral syphilis.—This subject is too large to be dealt with at any length in the present work, and it must suffice to mention briefly the chief changes that are found.

The lungs and heart are not often affected, but the former may be the seat of fibroid induration, and in *the latter* organ gummata may develop.

The abdominal viscera are more frequently diseased. In the liver and spleen gummata are common, and in the former viscus the capsule may be thickened by peri-hepatitis, and bands of fibrous tissue may develop in its substance; by the contraction of these bands the liver becomes puckered, and its surface deeply fissured and irregularly lobed. Gummata may form in the kidneys also, but are less common than in the liver and spleen. In all these viscera there is often, in addition to other lesions, amyloid degeneration.

Both the brain and spinal cord are liable to gummatous disease, and sclerosis may result from the formation and contraction of fibrous tissue. The peripheral nerves also are occasionally the seat of syphilitic inflammation.

FIG. 7.



Section of a Syphilitic Testis, with gummata of various sizes.

In the testes gummata are met with; they occupy the body of the gland rather than the epididymis, and are prone to break down and discharge through the scrotum. A testis with gummatous growths is in *the early stage nodular* and of irregular shape, and

later on is often in great part destroyed; both testes may be affected.

The syphilitic diseases of the eye are both numerous and destructive; the most important are diffuse inflammations of the choroid and retina, and chronic inflammations of the iris and ciliary region.

The diseases of the bones, joints, and vessels in tertiary syphilis are described in the chapters devoted to these subjects.

CONGENITAL SYPHILIS.

Syphilis may be transmitted to the offspring by either parent, and, when inherited from the father, the mother may herself become infected from the child without the occurrence of any primary sore.

A syphilitic infant frequently shows no evident signs of disease at the time of birth, and none may appear for several weeks. In other cases the child is evidently syphilitic when born. The disease often results in the death of the fœtus whilst *in utero*, a fact which readily explains the frequency of miscarriage in mothers who are pregnant by syphilitic husbands.

One of the earliest symptoms of congenital syphilis is a difficulty in breathing, which has earned for the disease the popular name of "the snuffles." This is due to inflammation, and possibly ulceration, of the mucous membrane of the nose, with consequent catarrh and obstruction to the free entry of air. In bad cases, on account of the interference with the nasal respiration, the child has great difficulty in sucking.

Within a few weeks, **eruptions** appear on the cutaneous and mucous surfaces, especially on the buttocks. The eruption differs in different cases, and in different parts of the body in the same case. Sometimes there are rose-coloured spots, and with these may be mingled others of a distinct coppery *colour.* On the palms of the hands and soles of the *feet the eruption* is generally squamous, and the

epidermis desquamating. Around the anus, in the groins, and at the angles of the mouth mucous tubercles are common. Occasionally the eruption is vesicular, and large bullæ are formed; to such a rash the name of "syphilitic pemphigus" is applied. The whole skin is, in bad cases, much wrinkled, dry, and dirty, and the child looks prematurely old and wizened. Cracks and fissures are common about the angles of the mouth, and often leave pale radiating scars which permanently mark the patient and afford valuable evidence of the disease.

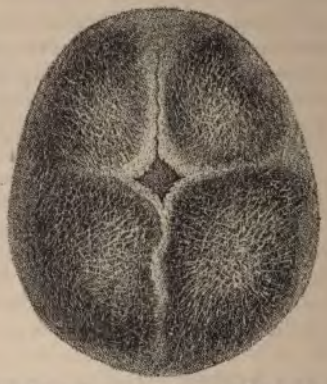
There is frequently considerable disturbance of the gastro-intestinal tract, with tumid abdomen and diarrhœa. The abdominal viscera may be enlarged either by amyloid disease or by simple congestion and fibroid thickening. The milk-teeth are late in being cut, and are liable to early decay; they do not, however, exhibit any change which is typical of syphilis.

The **osseous system** exhibits lesions which are amongst those most characteristic of the disease. They have been especially described by Drs. Barlow and Lees in England, and by Professor Parrot in France. These lesions are of two kinds—(1) **atrophic,** (2) **osteophytic.**

In the bones of the skull the atrophic lesions are of two varieties. In the one the bone is not diminished in thickness, but its substance undergoes a degenerative change, with the production of a gelatinous-like material, the bone-salts being removed. In the other there is simple atrophy of the cranial bones at those parts where they are exposed to the greatest pressure, the bone being thinned away until the brain is only covered by a transparent membrane. In this condition —which is almost exactly similar to that which is met with in rickets, and to which also the name of "craniotabes" is applied—the soft places in the skull can be readily felt by the finger during life; this is not *the case with the gelatiniform* degeneration.

The osteophytic lesions of the skull are very typical. In them there is a production of new bone from the periosteum, with consequent thickening of the

FIG. 8.



Skull from a case of Congenital Syphilis, showing the symmetrical bosses over the frontal and parietal bones which result from periostitis.

calvaria. This thickening occurs in very definite situations, and is almost invariably symmetrical. The sites for the thickening are the parietal and frontal bones on each side of the middle line, and in close proximity to the anterior fontanelle. In these situations, rounded, raised bosses of bone are formed, which sometimes attain a thickness of half an inch or more, and produce a most peculiar and characteristic appearance. Skulls so altered in shape are frequently called "natiform."

In the long bones the atrophic lesions are limited to the epiphysial ends. They are characterized by excessive calcification of the cartilage matrix, and the consequent formation of a very imperfect bone, and by the absorption of the bone already produced. In consequence of these alterations in structure, the

attachment of the diaphysis to the epiphysis becomes weakened, and complete separation is readily produced by the application of slight violence. When this separation occurs, suppuration occasionally ensues. In these cases of disease of the epiphysial ends, there may be a spurious paralysis, which is dependent upon the pain caused by movement as well as on the inherent weakness of the bone. Gelatiniform degeneration, such as affects the skull, is also met with in the long bones.

The osteophytic lesions are much more common than are the atrophic ones; the bones most commonly affected are the humerus, tibia, femur, and ulna, although no bone is altogether exempt. The formation of osteophytes is in some cases very extensive, and the osteophytes themselves present various appearances. In one variety, described by Parrot as the "osteoid," there is a production of new bone which is rather more spongy than normal osseous tissue, and is deposited in a series of layers placed one on the other, and each separated from the one beneath by a layer of medulla. In other cases the new formation beneath the periosteum is hardly at all calcified, and consists rather of fibrous tissue of a yellowish colour, slightly vascular, and simulating the animal matrix of bone. To this variety of osteophytic growth Parrot has applied the term "rachitic," but between it and the osteoid variety all grades may be found.

The above are the chief forms in which congenital syphilis manifests itself in the infant. Later in life other changes occur, which are too extensive to permit of lengthened description.

The cornea may be the seat of interstitial keratitis, an affection which commences in one eye and goes on to produce a more or less complete opacity of the whole cornea, but afterwards tends to clear up, and generally leaves only a few slightly opaque patches. The other eye begins to be affected at the time when the eye first attacked is improving, and passes through

similar stages of disease. The retina, the iris, and the choroid may be attacked by chronic inflammations. **Deafness** is liable to supervene very suddenly in early childhood, and to result in complete loss of hearing. It is apparently of nervous origin, and occurs independently of all external cause or apparent change in the conducting media. Chronic inflammation of the tympanum, with thickening of the membrane, is also met with in congenital syphilis.

The **permanent teeth** are in some cases deformed in a very typical manner. The central incisors are small and ill-developed, are separated from one another by a larger space than is usual, and are deeply notched on their cutting edges. It is to this notching that the greatest importance is to be attached. The lateral incisors and the canines are brittle, and the enamel is broken away at their free edges so as to leave a portion of the dentine protruding, like the peg of a peg-top, from the rest of the crown. All the teeth are liable to premature decay.

Ulcerations of the skin and gummata are of common occurrence in congenital syphilis; they do not differ from similar lesions in patients who have acquired the disease.

Chronic osteitis and periostitis are not infrequently met with in children of about six to twelve years of age. They affect chiefly the long bones, and in some cases attack several bones in the same patient, causing much deformity by the great thickening, as well as curvature and lengthening, which they produce.

CHAPTER XV.

TUMOURS.

A TUMOUR is a mass of newly formed tissue tending to grow and persist independently of the structures amongst which it is placed, and not serving any useful or physiological purpose. Thus, a tumour differs in all these particulars from a mere hypertrophy, which is commonly the direct or indirect result of local changes in nutrition, or is a consequence of increased physiological requirements, and which, moreover, instead of persisting, as a tumour usually does, is liable to subside when the stimulus which induced it has passed away. In another respect also a tumour differs from a mere hypertrophy, for, whilst in the latter the natural shape of the organ or tissue is preserved, a tumour forms a definite swelling or outgrowth, which usually spoils the normal symmetry of the part.

From inflammatory swellings a tumour differs in its tendency to persist, and not to terminate in resolution or suppuration; in its origin, which is frequently independent of all exciting causes; and in its intimate structure, which is usually materially different from that seen in inflammatory growths.

Again, a tumour being defined as a "mass of newly formed tissue," it is evident that swellings caused by extravasation of blood, by displacement of an organ, or by distension *with fluid of a pre*-existing cavity, such

as the tunica vaginalis or a bursa, cannot be included under this head.

CAUSES OF TUMOURS.

The causes of tumours are but little known, and even in those cases where their origin is distinctly traceable to injury or irritation we are at present quite unable to explain why in the vast majority of cases these usually produce inflammatory changes, whilst in the few they cause tumour-growth. The following theories have been advanced, and, as they all have something to support them, they may be briefly considered.

First, **inclusion theory, or embryonic hypothesis of Cohnheim.**—According to this, tumours are developed from embryonic cells, which, having been produced in greater numbers than are required for the formation of the fœtal tissues, remain in the locality in which they originally grew, and are lighted up into active growth either by the application of some artificial irritation or by the normal physiological activity of the part excited in a natural manner.

In support of this theory it is pointed out that moles, which are composed of connective-tissue cells, may develop in later life—and especially if irritated—into melanotic sarcomata; that the exostoses which are common at the articular ends of long bones undoubtedly develop from portions of epiphysial cartilage which have been left uncalcified in the shaft; and that many tumours originate in parts of the body in which structures present in fœtal life have been suppressed, or in parts where, in the process of closure of clefts or involutions of epithelium, it appears probable that more cells than could be utilized might have been included. For example, epithelioma is most common at the junction of mucous membrane with skin, and in parts, like the rectum and uterus, where a junction has been effected during fœtal life between the viscera and the surface of the body. Although,

however, this theory is an attractive one, it by no means accounts for even a considerable proportion of all tumours, and is not sufficiently supported by either physiological or histological research to allow of its general acceptance.

Second, **hereditary influence.**—In a certain number of cases of tumour a clear family history of similar growths may be obtained. This of course does not prove that tumours are of constitutional origin, for they may be inherited as local affections, just as may club-foot or other deformities.

Third, **irritation and injury.**—Whilst fœtal inclusion and hereditary taint may act as predisposing causes, irritation and injury may be considered as exciting causes of tumour-growth. Thus irritation of the skin by acrid matters may produce warts, *e.g.*, in workers in tar or petroleum, or may promote epithelioma, as in sweeps' cancer of the scrotum. Again, the mechanical irritation of a mucous surface, such as that of the lip or tongue by a sharp tooth, a jagged pipe, excessive smoking, &c., may result in the production of a similar growth.

But, whilst long-continued irritation often precedes warty or epitheliomatous tumours, the occurrence of sarcomata is influenced rather by direct and sudden injury, especially in the form of contusion. Thus a blow on the testis may precede sarcoma of that organ, and a similar history is not uncommon in periosteal sarcomata of bone.

Fourth, **physiological activity and decline.**—Sarcomata are especially prone to develop in early life in rapidly growing connective tissues, whilst carcinomata, grow in glands and other structures undergoing retrograde change, such as the mamma and uterus after the child-bearing period.

DEVELOPMENT AND DEGENERATION OF TUMOURS.

Whatever may be the cause or causes of a tumour,

when once it has developed, it almost always persists, and commonly continues to grow. It is true that some growths occasionally disappear spontaneously, *e.g.*, warts and lipomata, and that others, *e.g.*, the cancellous exostoses of the long bones, after a time cease to increase in size. These, however, are exceptions, and a tumour, as above stated, is characterized both by its persistency and its tendency to increase.

In some cases the structure of a tumour undergoes changes in its further development, and, putting aside for the present the ulceration which is common in malignant growths, it may be said that these changes are generally of a degenerative nature.

Calcareous degeneration is one of the commonest changes, and is often seen in enchrondromata, and more rarely in fatty tumours whose rate of increase is very slow or which have ceased to grow.

Mucoid degeneration is also seen in cartilaginous tumours as well as in many of the sarcomata, and is characterized by a gelatinous, semi-translucent appearance, or else by the formation of a cyst containing viscid fluid resulting from liquefaction of the matrix.

Fatty degeneration is met with especially in the epithelial cells of cancerous growths, but occasionally in the sarcomata and in innocent tumours.

Inflammation is a rare complication of malignant tumours, but is still more rarely met with in innocent growths. It is characterized by the usual local signs, and may terminate in suppuration. I have seen this in both carcinomata and sarcomata—in several cases of the former in the female breast, and in the latter in the neck and testis. It is a complication to be remembered, for the presence of pus is usually to be looked upon as contra-indicating new growth.

Sloughing is a very rare occurrence in tumours, and is limited to a few instances of large fatty or soft fibrous masses, and to cancers.

***Hæmorrhagic* infiltration** is often seen in soft

sarcomata, and more rarely in other tumours; it sometimes causes a rapid increase in size of cystic growths, and may thus simulate malignancy.

DIFFERENCES BETWEEN INNOCENT AND MALIGNANT TUMOURS.

All tumours are for clinical purposes roughly divided into two large groups, the **innocent** and the **malignant.** To the special characteristics of each of these groups it will now be necessary to turn before passing on to consider the structure of the different forms of new growth.

Malignant tumours differ from innocent ones in the following particulars:—1, Mode of growth; 2, glandular affection; 3, dissemination; 4, affection of the general health; 5, local recurrence after removal.

1. **Mode of growth.**—All malignant growths tend to *infiltrate* the tissues in which they develop, and in this respect differ essentially from innocent tumours, such as lipomata, fibromata, &c., which simply push the structures to one side, or separate them from one another. Malignant growths are practically never thoroughly encapsuled, but blend with and are inseparable from the structures around them. Into these they grow, and on these they feed, so that in time the tissues are replaced by the growth. But, in addition to infiltration, a malignant tumour *increases with much greater rapidity* than does an innocent one. Its blood-supply is large, its cell multiplication rapid, and within three or four months it may attain a considerable size. The skin covering it is at first tightly stretched, but soon becomes red and shiny, then dimpled, puckered, and adherent, and finally, giving way, allows the protrusion of a bleeding, soft, pulpy mass. Exposure to the air is soon followed by decomposition, with foul smell, and fetid *secretion, and the patient* is worn out by the com-

bination of septic conditions and profuse discharge of blood and pus.

2. **Glandular affection.**—One of the best marked and most widely recognized signs of malignancy is the occurrence of secondary growths in the neighbouring lymphatic glands. Enlargement of glands near a tumour may be due to irritation or inflammation, but these have nothing to do with the glandular affection under consideration, which consists in a reproduction in the gland of the exact counterpart of the primary growth, so perfect that any slight peculiarities in the original tumour can be easily recognized in the glandular enlargement.

But although glandular affection is good evidence of malignancy, whether the glands shall or shall not be occupied by secondary growths in any given case depends on two conditions—(*a*) the character, and (*b*) the locality of the growth.

As regards the character, it may be said that, speaking generally, the carcinomata more often cause glandular infection than do the sarcomata, and that the epitheliomata are of all tumours those most likely to give rise to this complication. The sarcomata do, however, in many cases affect the glands, one variety —the melanotic—invariably doing so.

As to locality, carcinomata in certain situations, such as the œsophagus, stomach, and superior maxillary bone, seldom cause secondary growths in the lymphatics; whilst, on the other hand, sarcomata of the testis always affect the glands, though similar growths in the breast hardly ever do so. For further information on these points reference must be made to the chapters on the diseases of the various tissues and organs.

3. **Dissemination.**—The reproduction of a growth in other parts of the body, often far removed from the seat of the primary tumour, is justly regarded as evidence of the worst kind of malignancy. No *viscera* are exempt, and the bones, muscles, and

central nervous system may any or all be implicated. As in the case of the glands, the secondary tumours exactly resemble the primary growth, and the occurrence or absence of dissemination is dependent on the structure and position of the primary tumour. The growths which disseminate most rapidly are the round-celled sarcomata and the encephaloid cancers.

4. **Affection of the general health.**—The term "cancerous cachexia" has for long been employed to indicate the wasted form and enfeebled health which so often accompany the development of a malignant tumour; and, although the old idea that the cachexia was of a special kind peculiar to cancers is no longer upheld, there is no doubt that the general health does become affected, and that a patient often wastes to an extent which is out of proportion to the apparent demands made by the disease upon his vital resources. Emaciation becomes more marked when the viscera are implicated, and special symptoms are developed according to the particular viscus affected.

5. **Local recurrence.**—Almost all tumours which show their malignancy in one of the ways already mentioned are also prone to recur locally when removed; but many growths which do not tend to become disseminated do tend to recur locally and sometimes to affect the glands. Such growths as these are said to have a "limited malignancy," the chief of them being the fibro-sarcomas or recurrent fibroids of the skin and subcutaneous tissues, the rodent ulcers, and to a less extent the cutaneous epitheliomata of the body and of the lips. In some cases the tumour recurs time after time in the scar left by the operation, and may, by its local extension and implication of vital structures, destroy life without causing any glandular affection or becoming disseminated in the viscera.

CLASSIFICATION OF TUMOURS.

All tumours may be placed in one of three classes—

I., connective-tissue growths; II., epithelial growths III., cysts.

Both the first and second classes may be again sub divided into innocent and malignant, and the who tabulated according to their structure as follows:—

I. Connective-tissue tumours—
  Innocent:
    Fibroma.
    Myxoma.
    Lipoma.
    Chondroma.
    Osteoma.
    Lymphoma.
    Lymphangioma.
    Myoma.
    Neuroma.
    Angeioma.
  Malignant:
    Sarcoma.

II. Epithelial tumours—
  Innocent:
    Adenoma.
    Papilloma.
  Malignant:
    Carcinoma.

III. Cysts.

In the following pages the general structur the various growths will be described; but, as t clinical course and behaviour vary much with t position, I have chosen to deal with them in deta the chapters on the different organs and tissue the body.

CHAPTER XVI.

INNOCENT CONNECTIVE-TISSUE TUMOURS.

ALL the connective-tissue tumours are developed from connective-tissue cells, which, in the case of the innocent growths, are further developed into some structure which is an exact imitation of one or other of the various connective tissues found in the normal adult body. In the malignant growths—the sarcomata—the cells remain in a more or less undeveloped or embryonic state, and form large masses such as are only met with normally in the fœtus.

FIBROMATA.

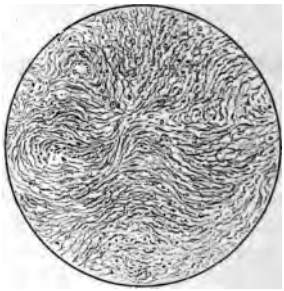
The fibromata are tumours composed of fibrous tissue, and just as in the human body fibrous tissue may be loose and succulent, *e.g.*, in the scrotum and eyelids, or dense and firm, as in the ligaments and tendons, so also the fibromata may be soft or hard. In the one case they are composed of loose fibrillar tissue with large spaces and many cells, in the other of densely packed bundles of fibres closely interlaced. The fibromata grow slowly, and are but slightly vascular.

The soft fibromas are most common on the inner side of the upper arm and thigh, close to the axilla or the perineum, and are more rarely met with in the labia and scrotum, on the scalp, and in the subcutaneous tissue in *other parts of the body*. They often attain

a considerable size, and may weigh several pounds. They are commonly pedunculated and pendulous. Occasionally fluid accumulates in the intercellular spaces, and forms cysts.

The hard fibromata occur on the periosteum of the jaw-bones as epulides, or on that of the nasal

FIG. 9.



Hard Fibroma from the Subcutaneous Tissue.
(Crouch, $\frac{1}{2}$ inch.)

bones as fibrous polypi. More rarely they are seen in the inter-muscular septa, on the nerves as "false neuromata," as well as in the breast, where, mixed with gland tissue, they are called adeno-fibromata.

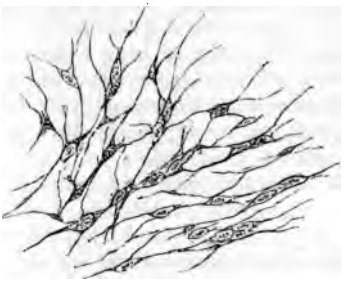
MYXOMATA.

Myxomata are tumours composed of mucous tissue. There are all grades between a soft fibroma and a myxoma, and the latter may be justly looked upon as a soft fibroma the intercellular substance of which has been replaced by mucin. Such a metamorphosis, if complete, would leave only the branched connective-tissue cells, enclosing spaces containing viscid fluid, but it is very rarely that a pure myxoma of such a structure is found, all those that I have myself examined containing some intercellular fibrous tissue.

The myxomata form soft, gelatinous semi-translu-

cent tumours, generally pedunculated, and yielding a viscid fluid on section. The microscope shows swollen fibrous tissue, and a network formed by the branching processes of connective-tissue cells.

FIG. 10.



Myxoma from the Middle Turbinate Bone.
(Crouch, $\frac{1}{6}$ inch.)

Secondary changes are common, for, on account of the delicacy of their structure, extravasations of blood into the substance of the myxomata are of frequent occurrence, and, the thin pedicle being liable to become twisted, the tumours may inflame or slough.

Clinical characters.—Myxomata may develop at any time of life, and are almost limited to mucous surfaces, such as the nose, rectum, bladder, uterus, &c., where they form the well-known mucous polypi.

LIPOMATA.

Lipomata are tumours composed of fat. They form lobulated growths, and may attain a great size, sometimes weighing many pounds. They are surrounded by a firm fibrous capsule which is closely adherent to the neighbouring tissues, though loosely attached to the tumour. Of this fact advantage is taken in operations for the removal of such growths, the capsule being freely opened, and the tumour easily shelled out

from within it. A lipoma, on section, is of a yellowish colour, and is indistinguishable from subcutaneous fat except by the greater firmness of its fibrous matrix. Microscopical examination shows that the fat is contained in connective-tissue cells, which are held together by a delicate network of fibres. The cells are larger than those usually seen in normal fat.

Secondary changes are not common in the lipomata, but in those which are of very long standing, and especially in those which have ceased to grow, calcification is of occasional occurrence. When they are very large, and subjected to pressure, the skin over them is sometimes ulcerated.

Clinical characters.—Lipomata are generally met with in people over middle age, and in those who are stout rather than in thin subjects. They may occur in the subcutaneous tissue of any part of the body, but show a distinct preference for the dorsal surfaces of the trunk and limbs, and are in some cases apparently the result of friction or pressure. Common situations for them are the subcutaneous tissue of the neck, shoulders, lumbar and gluteal regions. Their capsules are attached by small fibrous processes to the skin, so that the latter becomes dimpled or puckered if attempts are made to raise it from the tumour. In most cases lipomata are superficial to the muscles, though occasionally they dip beneath and between the latter. Other situations in which deep-seated lipomata occasionally occur are the spermatic cord, the omentum, and the viscera.

Diffuse lipoma is a form of fatty tumour which is not limited by any capsule. It is simply a local overgrowth of the fat normally found in the subcutaneous connective tissue, from which it does not differ in any respect. The patients in whom diffuse lipomata are found are usually stout men over middle age, and those who are of intemperate habits appear specially liable to be affected. The most common *positions* for these growths are the submental regions,

where they form pendulous masses, looking like an exaggerated double chin; the back of the neck and post-mastoid regions, where they are usually symmetrical; the groins, scrotum, and abdominal walls.

CHONDROMATA.

The chondromata are tumours composed of cartilage.

They vary much in size according to their position and attachments, are surrounded by a fibrous capsule, and are often nodulated. Their cut surface is divided into lobes, and is either bluish-white, smooth, and glistening, or fibrous and striated; some, again, are soft and gelatinous on section, and present a granular or ground-glass appearance. Each tumour is closely attached to its capsule, which forms for it a sheath or perichondrium. Microscopical examination shows different structure in different cases. In some the

FIG. 11.

Hyaline Enchondroma from the Scapula.
(Crouch, $\frac{1}{6}$ inch.)

matrix is hyaline, as in articular cartilage; in others it is fibrous, as in fibro-cartilage. The cells are sometimes enclosed in groups of three or four in capsules; in other tumours they are not encapsuled, and are *scattered singly throughout* the matrix. The cells

vary much in size even in the same tumour. They are generally round or oval, but occasionally polyhedral or stellate.

Secondary changes are of very common occurrence in chondromata. The intercellular substance in these tumours is exceedingly prone to undergo mucoid softening, the matrix being converted into a sticky fluid, and forming cysts. Calcification is also common. It occurs especially in the more central parts of the growth, the salts being first deposited in the nuclei of the cells. Ossification is not common in pure enchondromata, but does occasionally occur.

Clinical characters.—The enchondromata are most often met with in the bones of the hand, and more rarely in the foot, the long bones, and the pelvis. They grow also from the rib-cartilages, and are specially liable to spring from two or three of the latter rather than from any single one. In the soft tissues they are found in the parotid, testis, and breast; in the latter very rarely, and in the former seldom unmixed with sarcomatous or other tissue.

OSTEOMATA.

Osteomata are tumours composed of bone. They almost always grow from some part of the osseous system, and are fully described in the chapter on "Tumours of Bone." Very rarely, osteomata are also met with in the soft tissues, and examples have been recorded of bony growths in the lungs, brain, and parotid gland. In the muscles also single bony growths are met with, whilst in the disease known as "myositis ossificans" there is a formation of bone in many parts of the muscular system.

The **lymphomata** and **lymphangiomata** are fully described in the chapter on "Diseases of the Lymphatic System."

MYOMATA.

The myomata are tumours composed of muscular

tissue, which is almost always of the unstriped or involuntary variety, and is frequently mixed with much fibrous tissue.

Myomata form rounded, encapsuled tumours whose cut surface is firm and fibrous. A myoma is softer than a hard fibroma, and generally not so white and shiny. Microscopical examination shows that the growth consists of long, spindle-shaped fibres with central nuclei, placed with their long axes parallel, and held in apposition by a framework of fibrous tissue. The myomata are but little vascular.

Fig. 12.

Uterine Myoma. (Crouch, $\frac{1}{8}$ inch.)

Secondary changes in these tumours are common, especially when they occur in the uterus; there they are very liable to become calcified.

Clinically, myomata are found in the uterus and prostate, and infinitely more rarely in the intestine, stomach, and œsophagus.

Striped muscle is met with in mixed tumours only, chiefly in sarcomata of the kidney in young children.

NEUROMATA.

Neuroma is a term which is usually applied indiscriminately to all tumours growing on a nerve-trunk, those which are composed of nervous tissue being called "true neuromata," those composed of fibrous, myxomatous, or sarcomatous tissue being named "false neuromata."

True neuromata are very rare. They may be composed of either medullated or non-medullated fibres, and cases have been described in which neuromata in connection with the central nervous system have been found to contain branched nerve-

cells also. True neuromata form rounded or oval swellings of small size. The nerve-tubes of which they are composed are usually not continuous with those of the nerve-trunk to which they are attached, but form an irregular network mixed with a varying amount of loose connective tissue.

The most common form of **false neuroma** is composed of fibrous tissue, but myxomata, gliomata, and sarcomata are also met with. The latter differ from the fibromata in the greater rapidity of their growth, in their tendency to infiltrate rather than simply to push aside the nerve-fibres amongst which they grow, in their greater softness, and in the gelatinous, homogeneous appearance of a freshly cut surface.

The pressure of a neuroma on the nerve-fibres amongst which it lies may cause much pain, may induce sensory or motor paralysis, or cause trophic lesions of various kinds in the peripheral parts. Neuromata are sometimes multiple, and cases have been recorded in which tumours were found on almost every nerve in the body, amounting in all to several hundreds.

The bulbous swellings which form on nerves after injury, and which are sometimes named "traumatic neuromata," are not tumours in the ordinary sense of the word, and are described in the chapter on "Injuries of Nerves."

ANGEIOMATA.

The angeiomata, or vascular tumours, are growths composed of blood-vessels, and are commonly divided into two classes—the **simple** or **capillary**, and the **cavernous** or **venous.**

The **simple** or **capillary angeiomata** are commonly known as "**nævi**," and are of congenital origin, although their size at birth is often minute. A simple nævus is composed of a fibrous stroma containing many large, and thin-walled capillaries, which

frequently present irregular pouches or bulgings, and anastomose very freely. In almost all capillary nævi there are also a certain number of arteries and veins, such as are met with more especially in the cavernous variety.

Clinical characters.—This form of nævus is found most often on the face and neck, although no part of the surface of the trunk or limbs is entirely exempt. In colour cutaneous nævi vary, but are more often bright red than dusky and blue. The extent of skin implicated also differs much in different cases, but the growths are almost invariably but little raised from the surface, are soft and spongy to the touch, and can be made to disappear almost entirely by firm pressure.

Many capillary nævi, if left alone, gradually shrink, the blood-vessels composing them being obliterated.

Cavernous or **venous angeiomata** are most often found in the skin and subcutaneous tissues, where they form "venous nævi." These tumours closely resemble in their structure the erectile tissue of the penis, being composed of a fibrous stroma enclosing large irregular cavities or spaces filled with blood, which open directly into the neighbouring veins and arteries. The cavities are lined by tessellated endothelium, and appear to be formed both by dilatation of pre-existing capillaries, with absorption of the fibrous stroma separating them, and by the development of new vessels.

Clinical characters.—The venous nævi, which involve the skin as well as the subcutaneous tissue, form irregular, bluish, or purple swellings, which are soft, and capable of being greatly diminished by pressure. When, however, they are situated entirely beneath the skin, they may cause but little discoloration. In some of these cases a considerable quantity of fat is found mixed with the cavernous tissue, and the tumour feels like an ordinary lipoma. Such *growths have been named* "nævoid lipomata."

CHAPTER XVII.

MALIGNANT CONNECTIVE-TISSUE TUMOURS, OR SARCOMATA.

A sarcoma is a tumour composed of embryonic connective-tissue cells, and develops from one of the various connective tissues of the body. The type of the connective-tissue cell is the leucocyte, but many of the cells of the sarcomata differ from leucocytes both in shape and size.

In a typical sarcoma there is no definite stroma, the cells being closely packed and uniformly distributed throughout all parts of a section. Blood-vessels are numerous, the smaller arterioles having very thin walls, and often appearing as narrow channels bounded merely by the cells of the growth. No lymphatics have been demonstrated.

CLASSIFICATION.

The sarcomata may be divided into four chief groups—(i.) **round-celled,** (ii.) **spindle-celled,** (iii.) **mixed-celled,** (iv.) **giant-celled** or **myeloid.**

Round-celled sarcomata.—These tumours are composed of round, granular cells, with no definite cell-wall, often multinucleated, and in any individual tumour usually of the same size throughout. The cells vary much in size, however, in different growths. In some they are no larger than a leucocyte—small *round-celled* sarcoma; whilst in others they are more

than double or treble this size—large round-celled sarcoma. The matrix is usually soft, granular, or homogeneous, and abundantly supplied with vessels.

FIG. 13.

Large Round-celled Sarcoma. (Crouch, $\frac{1}{8}$ inch.)

FIG. 14.

Spindle-celled Sarcoma from the Subcutaneous Tissue. (Crouch, $\frac{1}{8}$ inch.)

The **spindle-celled sarcomata** consist of closely packed, oval, spindle, fusiform, or oat-shaped cells,

FIG. 15.

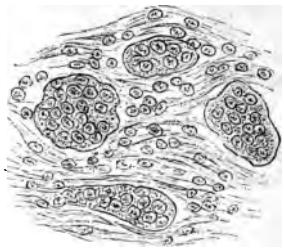
Mixed-celled Sarcoma. (Crouch, $\frac{1}{8}$ inch.)

which are generally granular and multinucleated, have no definite *cell-walls, and* are mostly arranged

with their long axes parallel to each other. They vary in size in different tumours, but are usually all of about the same dimensions in any individual growth. They are collected in bundles, and are embedded in a matrix which, though sometimes homogeneous, is occasionally fibrillated. They are not so vascular as the round-celled variety.

The **mixed-celled sarcomata** are composed of cells of various shapes and sizes, whose general characters are similar to those of the round- and spindle-celled growths.

FIG. 16.



Myeloid Sarcoma from the Lower Jaw. (Crouch, $\frac{1}{8}$ inch.)

The **myeloid** or **giant-celled sarcomata** are characterized by the presence of large multinucleated cells, such as are seen in the marrow of bone, and are often some twenty to thirty times the size of a leucocyte, containing from ten to forty nuclei. Mingled with these are a number of oval, spindle, or round cells.

VARIETIES.

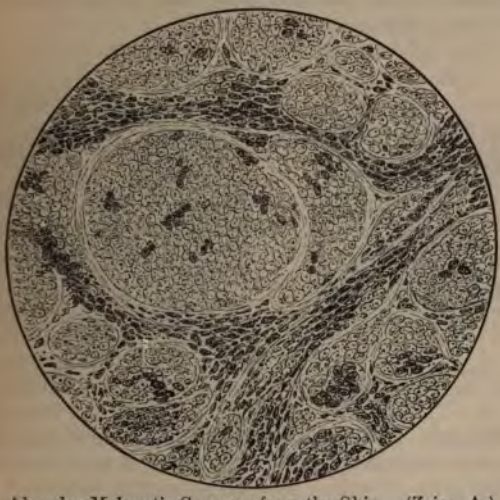
Although the sarcomata may be primarily subdivided into the above four groups, they nevertheless present numerous well-defined varieties which may now be briefly described.

Melanotic sarcomata. — These tumours are characterized by the presence of pigment, which is of a golden-brown colour when seen in minute quantities, but gives a dark-brown or black hue to the growths in which it is found. The pigment is often very irregularly distributed, and occurs both in the cells and in the intercellular matrix. Most of the melanotic sarcomata belong to the round-celled group, though *some of* them are composed of spindle cells; in the

majority of specimens the matrix is fibrous, and forms definite alveoli.

Melanotic sarcomata originate in parts which normally contain pigment—*e.g.*, the skin and the

FIG. 17.



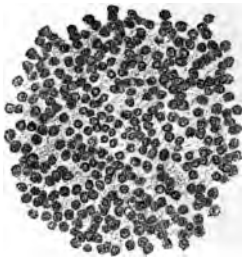
Alveolar Melanotic Sarcoma from the Skin. (Zeiss, A.)

choroid coat of the eye—and not infrequently commence in a mole or wart which has been irritated by caustics or imperfect attempts at removal. These growths are extremely liable to become disseminated in both the viscera and the skin, and it is very noticeable that in the latter situation none of the tumours ever attain any great size, often ceasing to grow when little larger than a hazel-nut. The lymphatic glands in the neighbourhood of a melanotic growth are almost always affected sooner or later by secondary deposits, and in advanced cases pigment granules may be found in the urine.

Lympho-*sarcoma*.—*The* lympho-sarcomata are

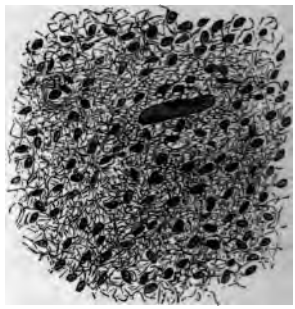
composed of small round cells, about the size of leucocytes, enclosed in a fine meshwork of connective tissue whose general arrangement is precisely similar to that seen in the medullary portions of a lymphatic gland. These tumours originate in connection with lymphatic tissue, and are often seen in the lymphatic glands themselves.

FIG. 18.



Lympho-sarcoma from the Axilla. (Crouch, $\frac{1}{8}$ inch.)

FIG. 19.



Glioma from the Cerebellum. (Crouch, $\frac{1}{8}$ inch.)

Glioma and glio-sarcoma.—A glioma is a tumour composed of neuroglia, and is in many respects an innocent growth. Not infrequently, however, the neuroglia tissue is mixed with much round-cell growth, and forms a glio-sarcoma, a tumour which is softer, less definitely encapsuled, and more vascular than a simple glioma. Both these varieties occur almost exclusively in connection with the nervous system.

Hæmorrhagic sarcoma.—This is a term applied to certain forms of round- or spindle-celled growths which evince a great tendency to blood extravasations. The hæmorrhage, which is due to the extreme tenuity of the vessels, breaks up the cell-masses, and forms blood-cysts of various sizes surrounded by a thin layer of the original tumour. Many of these hæmorrhagic *sarcomata* are liable to be mistaken for simple cysts,

the amount of new growth surrounding the blood being frequently very slight.

Plexiform sarcoma or cylindroma.—This is a rare variety of sarcoma, composed of round or polygonal cells, and is characterized by a hyaline degeneration of those cells which are in the immediate neighbourhood of the blood-vessels. The unaltered cells consequently appear, on section, to be contained in alveoli with hyaline walls.

Psammoma (pearl tumour).—This form of sarcoma has hitherto been found only within the cranial cavity. It is characterized by the presence of concentric calcareous masses surrounded by fibrous tissue and attached to fibrous trabeculæ.

Secondary changes in the sarcomata.—The most common form of degeneration is that known as "mucoid." It usually commences in the most central portions of a tumour by the distension of the cells with a clear gelatinous fluid. Gradually the whole of the cell protoplasm is liquefied, and the mucous fluid is discharged. In this way cysts are developed in the midst of the new growth, and in some cases the matrix also seems to undergo a similar change. More rarely, sarcomata undergo fatty degeneration.

MIXED TUMOURS OF CONNECTIVE-TISSUE TYPE.

Between the sarcomata on the one hand and the innocent connective-tissue tumours on the other stand certain growths consisting in part of cells and in part of more fully developed tissue. The pure sarcomata are characterized by the embryonic nature of their cells; the innocent connective-tissue tumours, by the perfect development of their constituent structures. In the intermediate class are found growths which, whilst they consist in part of fully developed tissues, yet comprise many more cells than are found in the normal structures of the adult body. These growths are therefore *included under* the sarcomata, and a

prefix is used to indicate the tissue with which the sarcomatous elements are mingled. Thus a "fibro-sarcoma" or "fibrifying sarcoma" is a connective-tissue growth composed of a mixture of fibrous tissue and sarcoma; a "chondro-sarcoma" or "chondrifying sarcoma," a tumour of cartilage and sarcoma, &c.; and between such growths and sarcomata on the one hand, and innocent fibromas and enchondromas on the other no definite line can be drawn.

A fibro-sarcoma is composed of spindle cells and fibrous tissue, and all grades of development between cells and fibres can often be seen in the same specimen. These growths were formerly described as "recurrent fibroids."

A myxo-sarcoma consists of a matrix, such as has been already described under the myxomata, in which are scattered round cells.

An osteo-sarcoma is a form of sarcoma occurring in bones, in which a round- or spindle-celled sarcomatous growth is developed with and in an osseous matrix; the matrix of the sarcoma becomes, in fact, converted into bone.

A chondro-sarcoma is composed of a mixture of cartilage and sarcomatous tissue combined in varying proportions.

Naked-eye appearances of sarcomata.—Sarcomata differ much from one another in appearance. The most noticeable feature of their freshly cut surface is its homogeneous, structureless appearance, and the complete absence of fibrillation or striation; in this the sarcomata differ from almost all other growths. Those tumours which are purely cellular are soft, brain-like, and pulpy, of a dirty-white colour, and very friable. Some sarcomata, especially those which are undergoing mucoid degeneration, present a gelatinous or semi-translucent appearance, whilst others are mottled by blood extravasations. In proportion as the sarcomatous tissue is mingled with *fibrous,* cartilaginous, or other structures, so the

appearance on section of course differs. Some sarcomata present a fairly definite capsule, but the more cellular forms infiltrate in the manner common to all malignant growths. The myeloid sarcomata of bone are specially characterized by their reddish-brown or maroon colour, and their tendency to form blood-cysts.

Clinical characters of the sarcomata.—The clinical course run by the sarcomata differs not only with their microscopical structure, but still more with the locality and tissue in which they develop. The present paragraphs, therefore, deal only very briefly with this subject, and for further information reference must be made to the chapters on the tumours of the different organs and tissues.

Sarcomata occur in the young and middle-aged rather than in the old, and occasionally follow injuries, such as contusions. The more malignant the tumour, the more rapidly it grows and tends to disseminate. Round-celled growths are the most malignant of all, and may become widely diffused and destroy life within six or eight months of their commencement. The myeloid tumours are the least malignant of the pure sarcomata, and frequently do not recur after removal. Many of the fibro-sarcomata of the skin and subcutaneous tissue also show but little malignancy, merely tending to recur locally if removed, and not affecting distant organs.

The majority of sarcomata do not affect the neighbouring lymphatic glands, though whether they do so depends rather on their position than on their microscopical structure; *e.g.*, a round-celled sarcoma of the testis almost invariably causes secondary growths in the lumbar glands, whilst a tumour of the breast of a precisely similar structure practically never causes glandular growth.

If the skin over them becomes implicated, sarcomata fungate, and form soft, bleeding masses, which *discharge a mixture of blood* and pus.

In some cases the structure of a sarcoma varies with its recurrence, and the recurrent growths may present a different microscopical appearance from that of the tumour which was first removed. Thus the primary tumour may be a fibro-sarcoma with spindle cells, and the growth which recurs at the site of operation may be entirely cellular, without any fibrous stroma, and consequently of a more malignant character. On the other hand, the recurrent growth is sometimes less cellular and therefore more innocent than the primary tumour, and, as might be expected, the clinical course differs with the structure. Thus, the recurrent growth may grow more rapidly than the primary one, and, if again removed, may recur after a shorter interval; or the reverse may occur, and the second tumour may grow more slowly, and, after another removal, may not return until after a longer interval than that between the first operation and the first recurrence.

CHAPTER XVIII.

OCENT EPITHELIAL TUMOURS.

the connective-tissue growths, the epithelial
ɛs may be conveniently divided into innocent
ılignant, and as in the connective-tissue growths
ıocent tumours are formed on the type of some
the normal tissues of the adult body, so in the
ıt epithelial tumours the adenomata and
mata are reproductions of the normal glandular
pillomatous structures found in different parts.
rcinomata, or malignant epithelial growths, on
ıer hand, are formed of structures which have
nterparts in any of the normal tissues of the
ody, and thus are strictly comparable to the
ant connective-tissue tumours—the sarcomata.

PAPILLOMATA.

papillomata are tumours formed on the type
papillæ which are normally developed in the
ıd mucous membranes.
consist of a stroma composed of fibrous tissue,
is in some cases richly cellular, in others dense
rous. In this stroma are contained both blood-
and lymphatics, the whole growth being
ıtly very vascular. The surface is covered by
ium, which varies in its nature according to
ality of the growth. In papillomata on the
ıe epithelial cells are squamous, and are ar-
in *several layers, whilst* in growths from the

mucous surface of the bladder or intestine the cells are columnar and not so thickly placed.

FIG. 20.

Papilloma from the Anus. (Crouch, 1 inch.)

The fibrous stroma extends towards the free surface papillary processes, which in the "simple" papillomata are single and undivided, but in the "compound" papillomata are branched, giving off processes, which in their turn again bifurcate. The surface of a papilloma is generally irregular and villous, but is occasionally smooth, presenting no sign of subdivision of the stroma into papillæ.

Secondary changes are common in these growths, for their exposure on free surfaces renders them peculiarly liable to injury, and thus ulceration and hæmorrhage are of frequent occurrence.

Clinically, the papillomata are entirely innocent, and must be clearly separated from malignant tumours, such as epitheliomata, whose surfaces are also often covered by papillæ, but which differ structurally in the most essential details from simple papillary growths.

Papillomata are met with on the skin as warts and corns, and on the mucous membranes of the nares, tongue, bladder, larynx, and intestines.

In syphilis also, and in gonorrhœal discharges, *mucous tubercles* or condylomata, whose structure is

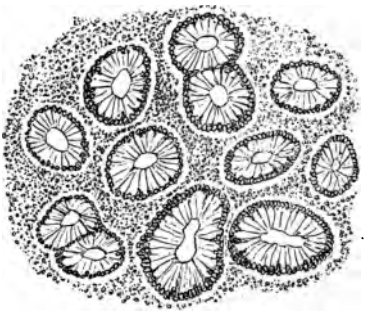
essentially papillomatous, are of common occurrence.

ADENOMATA.

The adenomata or glandular tumours are growths composed of gland tissue more or less perfectly developed, and are formed on the pattern of the normal gland tissue found in the different parts of the body from whence they spring.

Putting aside the lymphadenomata, which are described elsewhere, and the glandular hypertrophies, which are not to be included amongst the true tumours, the adenomata may be said to consist of acini and

FIG. 21.



Tubular Adenoma of the Rectum.
(Crouch, ½ inch.)

ducts when developing in a racemose gland, or of tubes when growing from the tubular glands. They differ from the malignant epithelial growths or the "atypical epithelial tumours" in that, whilst the latter are not formed after the type of the normal epithelial tissue from which they spring, the true adenomata are exact or close imitations of glandular structure, the tubes and acini forming them having a definite lumen, and their epithelium being sharply defined *from the surrounding* tissue. The malignant

epithelial growths, again, are not encapsuled, but infiltrate the tissues amongst which they grow, whilst the adenomata do not infiltrate and are generally encapsuled. Although composed of gland tissue, the latter in the adenomata is not physiologically active, and its secretion if formed is not discharged into the ducts of the gland in which it grows. In consequence of this, the tubes and acini are extremely liable to become distended and to form cysts.

The adenomata of the different glands are described in future chapters.

CHAPTER XIX.

MALIGNANT EPITHELIAL TUMOURS, OR CARCINOMATA.

THE carcinomata are tumours growing from, and composed of, epithelial cells, which are generally contained in spaces or alveoli whose walls are formed of fibrous tissue. Within the alveoli the cells are not separated from one another by any stroma or matrix, and, whilst varying in shape and size, closely resemble in their general characters the epithelial cells of the part from which they spring. They are frequently multinucleated, and increase both by fission and by endogenous cell-formation. The matrix is vascular, and blood-vessels run in the alveolar walls, though they do not penetrate into the alveoli or run amongst the cells as do the vessels of the sarcomata. Lymphatics are well developed, and accompany the vessels.

The following are the chief groups of the carcinomata:—

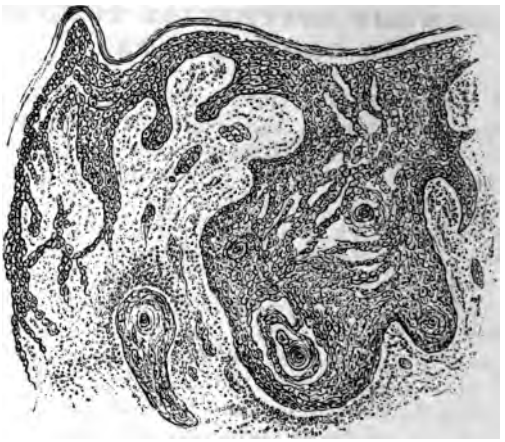
1. **Epithelioma, or squamous-celled carcinoma.**
2. **Rodent ulcer.**
3. **Spheroidal-celled carcinoma—**
   (*a*) Scirrhous.
   (*b*) Encephaloid.
   (*c*) Colloid.

4. **Cylindrical-celled carcinoma**; adenoid cancer; adeno-carcinoma.

EPITHELIOMA.

An epithelioma consists of a new growth of squamous epithelial cells, which not only grow, as in the papillomata, towards the free surface, but also infiltrate and destroy the subjacent tissues. Microscopically, these tumours are found to originate in ingrowths of solid columns of cells from the interpapillary processes

FIG. 22.



Epithelioma of the Lip. The epithelium has grown into the subjacent tissues, and has caused a considerable exudation of cells in its neighbourhood. (Zeiss, A.)

which are common to all cutaneous and mucous surfaces. As these ingrowths extend into the subjacent tissues they throw out lateral branches, which, uniting with similar offshoots from other columns, form an irregular epithelial network. At the same time that this ingrowth occurs an outgrowth also takes place, and a warty excrescence of epithelium develops, the

al cells of which soon break away, and thus he deeper parts of the growth. In this way ıant ulcer is developed, whose base and edges : formed by the tumour. This disintegration ıperficial cells continues with a rapidity equal ıf their development, and thus, whilst the new constantly extends amongst and destroys the t structures, the ulceration generally prevents

FIG. 23.

Cell-nests from an Epithelioma, showing the ıncentric arrangements and semilunar shape of ıe external layers of cells. (Crouch, $\frac{1}{4}$ inch.)

nour from attaining a considerable size. the ingrowing columns there is generally of irritation of the tissues into which the ıma is making its way, for the cells of the new behave as foreign bodies in respect to the other

tissues, and the growing edge of each column is thus surrounded by much small-cell infiltration.

The epithelial cells of which the growth is composed are usually large, very irregular in shape, often possessing processes, multinucleated, and sometimes in the process of proliferating by endogenous cell-formation. Embedded in the epithelial columns are **cell-nests,** which vary much in number and size in different specimens. They are composed of central cells of a rounded shape, which in some specimens are much broken down and degenerated. Around these are small crescent-shaped cells with their concavities inwards, and outside these again are layers on layers of cells similar in shape but of larger size. The nests are formed by the very rapid proliferation of cells at various foci in the tumour. The cells first formed at any focus are pushed towards the periphery by the constant and rapid growth in the centre, and become flattened or crescentic through the resistance offered by the surrounding tissues. The chief significance of a nest is that it indicates rapid cell-growth, and therefore, when occurring in the deeper parts of the skin, or in the subcutaneous tissues, is diagnostic of epithelioma, for no such formations exist under normal circumstances in this situation.

Locality.—The most common situations for epitheliomata are the junctions of mucous and cutaneous surfaces. They occur on the lips (usually the lower lip) and other parts of the face, the tongue, the larynx, the œsophagus, the rectum and anus; on the penis, the scrotum, the vulva, the os uteri; more rarely on the skin of the extremities or trunk, especially in the site of old scars, ulcers, or sinuses, and in the bladder.

Clinical characters.—Epithelioma is essentially a disease of late life, and is seldom seen before the age of forty. It commences as a warty or papillated growth, which increases rapidly and infiltrates the tissues amongst which it develops. The tumour

ulcerates early, the ulcer having a foul sloughy base and raised indurated edges formed of that part of the epithelioma which has not yet become involved in the ulcerative process. The destruction of tissue is at times very great, and is accompanied by much pain. The neighbouring lymphatic glands are early affected, and in them the epithelioma runs a course precisely similar to that of the primary tumour. The masses of growth in the glands commonly attain a much greater size than does the original tumour, and not infrequently suppurate. Secondary growths in the viscera are not common, although they do occur, and death generally results from direct extension to important structures, and from exhaustion caused by pain and by discharge of blood and pus.

It should be mentioned that, in addition to the squamous-celled carcinomata, epitheliomata composed of columnar cells grow from the mucous membrane of the nose and antrum.

RODENT ULCER.

A rodent ulcer is a tumour composed of embryonic epithelial cells, and is developed in the derma, apparently from the glandular structures, such as the sebaceous glands, the sweat glands, and the hair follicles, which are found in this situation. It thus differs in its origin from epithelioma, which is essentially an ingrowth of the surface epithelium.

The cell-growth invades the tissues in the form of large flask-shaped or irregular ingrowths, frequently separated from each other by several normal papillæ and interpapillary processes. The cells themselves are small and round, being usually not more than one-third as large as those forming the epitheliomata. They show a great tendency to become vacuolated, and thus form spaces in the centre of the ingrowing mass. In most specimens there are no cell-nests, and these, when present, are very small, ill-developed, and *sparsely scattered.* The epidermis is infiltrated from

below, and, being destroyed after a time, allows of the protrusion of the cell-growth, an event which is followed by ulceration or disintegration, as in the case of epithelioma.

FIG. 24.

Rodent Ulcer from the Face. The surface epithelium has not proliferated, and, beneath it, the derma and subcutaneous tissue are infiltrated with an irregular growth of small round and oval cells. (Crouch, ½ inch.)

Locality.—Rodent ulcer is almost limited to the face, and is most common on the side of the nose, at the inner angle of the orbit, on the forehead, and the prominence of the malar bone. It is rare on the lips and chin.

Clinical characters.—Rodent ulcer is seldom seen before the age of forty. It commences as a small wart or pimple, the centre of which, in time, ulcerates; the growth of the wart and the spread of the ulceration progress with about equal rapidity, so that at no time is there any large amount of new growth. Frequently the ulceration heals in one place whilst it extends in another, but the scar which forms is not stable, and soon again breaks down.

The growth of these tumours is essentially slow, *though the* rate of growth differs somewhat in different

cases. An ulcer as large as a sixpence is often found to be a year or more old. When fully developed, a rodent ulcer is a flattened growth of an irregular shape, with a grey, smooth, and glazed base, devoid of healthy granulations, and discharging thin, watery pus. In parts, a little ill-formed scar-tissue may be seen, and the surface is often covered by a scab. The edges are sometimes sharply cut and not raised, but more frequently are both raised and indurated. The lymphatic glands are never affected by secondary tumours, and the viscera remain throughout free from disseminated growths. Although large portions of the face are commonly destroyed, rodent ulcer is so slow in its progress that the patient often dies from old age or intercurrent disease before the tumour reaches a vital part, such as the brain. In some cases the whole of the lips, nose, eyes, and mouth are destroyed before death occurs.

SPHEROIDAL-CELLED CARCINOMA.

The spheroidal-celled carcinomata are subdivided into three groups: (1) Scirrhous; (2) Encephaloid; (3) Colloid.

Scirrhous carcinoma. — To the naked-eye a scirrhous carcinoma appears as a white, fibrous mass, very firm and dense, cutting with a peculiar grating or creaking sensation, concave on section, and with an irregular margin. The tumour is not encapsuled, and at its edge may be seen small masses of fat, or other normal tissues, which are being infiltrated by the growth, and which have, as it were, been entangled by it preparatory to being absorbed. The soft parts around the cancerous growth are puckered and drawn towards the tumour by the contraction of the branching processes which extend from the margins of the latter.

Examined microscopically, a scirrhous carcinoma is found to consist of spheroidal epithelial cells lying in *a stroma composed of* interlacing bands of fibres, and

containing a varying proportion of connective-tissue cells. The alveoli, or spaces, enclosed by these bands are very irregular in shape and size, and are smaller in the more central parts of the growth than at its periphery. The epithelial cells, though generally spheroidal, vary a good deal in shape and size, being larger and more fully developed where the alveoli are large, whilst in the most central parts of the growth they may often be seen to contain fatty granules. Some of the alveoli contain as many as thirty or forty cells or more, although in other portions of the

FIG. 25.

Scirrhous Carcinoma of the Breast (Crouch, $\frac{1}{8}$ inch.)

growth the latter lie in groups of but two or three, or in single file amidst the bundles of connective tissue.

Secondary changes in scirrhous carcinomata are of common occurrence, for, in addition to ulcerating when they reach a surface, they are liable to undergo fatty degeneration in their more central parts or to become the seat of blood extravasations and cysts. More rarely suppuration occurs, and pus is formed in the substance of the tumour.

Locality.—By far the most common seat of scirrhous carcinoma is the female breast, but this variety *of cancer* is also found in the uterus, œsophagus, *stomach, prostate*, and skin.

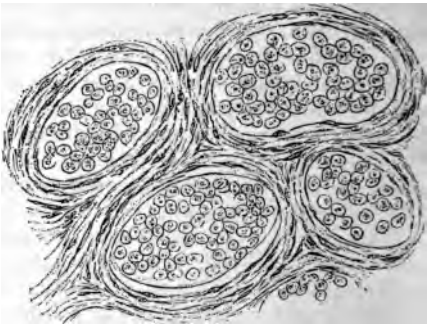
Clinical characters.—Scirrhous cancer is most common in women after the age of forty. It commences as a firm knotty lump which is at first painless, and may thus attain a considerable size before attracting attention. When fully developed the surface of the tumour is irregular, nodular, and very hard, sometimes feeling like a mass of cartilage. Though at first movable, the growth soon contracts adhesions, and causes puckering and retraction of the skin and adjacent parts. The rapidity of growth varies much in different localities, and in the same locality in different patients. After a variable time the skin or mucous membrane covering the tumour becomes involved, and a sloughing mass protrudes from which both pus and blood are discharged. The lymphatic glands in the neighbourhood are early affected by secondary deposits, and, as time goes on, the thoracic and abdominal viscera, and more rarely the bones, become the seat of disseminated growths.

Encephaloid carcinoma.—This variety of the spheroidal-celled cancers is of much more rare occurrence than the scirrhous growths. To the naked eye an encephaloid carcinoma presents a soft, greyish, or dirty-white, brain-like mass, mottled in places by hæmorrhages, frequently containing cysts, and readily reduced to a pulp by slight pressure. It is nowhere encapsuled.

Microscopically examined, an encephaloid carcinoma consists of a fibrous stroma enclosing alveoli in which are contained spheroidal epithelial cells. The alveoli are larger and more regular in size than in scirrhous cancer, and their walls are much more delicate, being composed of finely fibrillated connective tissue instead of the dense fibrous stroma of the scirrhous tumours. The epithelial cells contained in the alveoli constitute by far the greater portion of the growth. They are large and round, *with definite nuclei,* and well-developed cell-bodies;

they often contain much granular matter and many nucleoli.

FIG. 26.



Encephaloid Carcinoma of the Antrum. (Crouch, $\frac{1}{8}$ inch.)

Locality.—The female breast, testis, stomach, bladder, and superior maxilla are the parts of the body in which this form of tumour is found.

Clinical characters.—Medullary cancers are soft, elastic, or semi-fluctuating swellings, of extremely rapid growth, quickly involving the skin, readily fungating, causing early implication of the glands, and disseminating in the viscera with great rapidity. In many cases life is destroyed within a year of the first appearance of the original tumour. As many of the round-celled sarcomata were formerly included under the medullary cancers, these latter growths are generally supposed to be much more common than is really the case. Their occurrence is indeed of considerable rarity.

Colloid cancer.—Colloid cancer is merely a variety of scirrhous or encephaloid carcinoma in which the cells, and in many cases the stroma, undergo colloid degeneration. To the naked eye a colloid carcinoma presents an irregular network, the spaces of which are filled by a clear, jelly-like, or slightly

opalescent, gelatinous substance. The network is most open and the colloid matter most abundant in the central or oldest portions of the tumour, whilst the periphery is much like that of a scirrhous growth in its irregular, infiltrating edge, and nodulated surface.

Microscopically examined, a section shows the alveolation of the matrix and the masses of epithelial cells common to the other varieties of carcinoma. Some of the cells are of the same size and shape as those of the glandular tissue from which the growth

FIG. 27.

Section of a Carcinoma of the Breast. Many of the cells are distended with colloid matter, and in the lower part of the section is an irregular cavity caused by the bursting of some such cells.

springs, but others are filled in varying degrees with colloid matter which thrusts the nucleus to one side and distends the cell-body until it bursts. By a continuance of this process in the other cells, they are gradually destroyed, and their place taken by the colloid substance which now fills the alveolus. *The remains of the* walls of the ruptured cells can

often be seen after their contents have been discharged. In many cases the fibrous matrix also undergoes degenerative change, and the fibres composing it swell up with colloid matter, whilst their outlines become blurred and indistinct. As the walls of the alveoli are thus destroyed, the cavities of those contiguous to one another become continuous, and thus in the most central or oldest portions of the tumour, as already stated, the network is more open than at the edges.

Locality.—Colloid carcinomata are most common in the stomach, but are found also in the breast, intestines, and more rarely in other parts of the body.

In their **clinical characters** these tumours do not materially differ from the scirrhous cancers, and require no separate description.

The cylindrical-celled carcinomata are fully described in the chapter on "Tumours of the Rectum."

CHAPTER XX.

CYSTS.

A CYST is a closed sac with fluid or semi-fluid contents. The following groups are generally recognized:—

1. Cysts formed by distension of pre-existing tubes or cavities.
2. Cysts of new formation.
3. Cysts of congenital origin.

The cysts formed by distension of pre-existing tubes or cavities are the most common, and are developed in different ways. Thus, mucous cysts are the result of some obstruction to the ducts of the mucous glands, and sebaceous cysts to a similar retention of the products of the sebaceous glands, whilst cysts in the breasts or kidneys result from retention of the mammary or renal secretion. In other cases, again, the cysts are developed by distension of a cavity which normally has no duct or outlet. Thus cysts of the thyroid gland, enlarged bursæ, vaginal hydroceles, &c., are the result of an excessive secretion of fluid from the epithelial or endothelial cells of the respective parts.

Cysts of new formation develop in different ways. Some result from blood extravasations, as do the so-called "apoplectic cysts" of the brain and the arachnoid cysts; others, like the adventitious bursæ, result from the accumulation of fluid in the *lymphatic spaces of the* connective tissue; whilst a

third class are formed in connection with foreign bodies (*e.g.*, bullets) or parasites (*e.g.*, hydatids).

Cysts of congenital origin appear to be formed by the inclusion of portions of epiblast during the process of closure of the thoracic, abdominal, branchial, or other cavities.

In solid tumours, also, **degeneration cysts** are liable to form, especially in the sarcomata, enchondromata, and soft fibromata. These, however, are not to be included amongst the true cystic tumours.

Sebaceous cysts.—These are formed by blocking of the duct of a sebaceous gland, most often by dirt or by surrounding inflammation. They are most common on the scalp, face, neck, and shoulders, and are seen at all ages after childhood. In size they vary from a pea to a hen's egg. They are situated in the substance of the skin, and the latter, in consequence, cannot be moved freely over the swelling, whilst, on the most central portion of the tumour, a small black speck, which is the obstructed sebaceous duct, can often be distinguished. When large, the cyst extends into the subcutaneous tissue.

A sebaceous cyst contains sebaceous matter, the wall of the cyst being formed by the epithelial cells of the secreting portion of the gland, arranged in numerous layers, and placed upon a basement membrane of fibrous tissue.

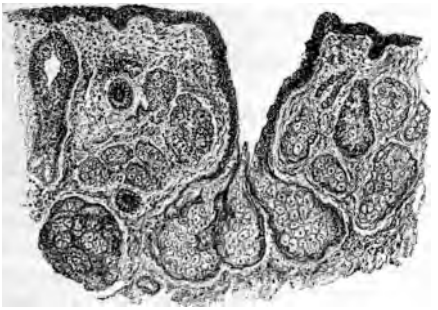
In some cases sebaceous cysts become inflamed and suppurate, and thus give rise to abscesses or ulcers, which are generally very slow to heal.

Dermoid cysts have a cyst-wall formed of true skin, with papillæ, hair follicles, sudoriparous and sebaceous glands. They are always of congenital origin, but frequently do not become noticeable before childhood or puberty. They contain sebaceous matter, and increase in size by the constant secretion of the sebaceous glands which line the cyst-wall, and empty their contents into its cavity. More rarely they *contain* bone, teeth, &c.—a circumstance which is

enerally accounted for by the supposed inclusion of ortions of mesoblast as well as of epiblast.

Dermoid cysts are common at the angles of the rbit and in the eyelids, where they are always found

FIG. 28.



Section of the Wall of a Dermoid Cyst of the Ovary, showing large sebaceous glands and cross-sections of hairs. (Crouch, ½ inch.)

neath the deep fascia, the skin being quite movable ver them. They also occur with some frequency in he ovary, and more rarely in the floor of the mouth, nd the testis.

CHAPTER XXI.

CONTUSIONS.

A CONTUSION is a subcutaneous, lacerated wound. The various soft tissues are torn, and, the vessels being injured, blood escapes and stains the neighbouring parts. The damaged structures are repaired by a process of plastic inflammation with organization of the inflammatory products into fibrous tissue; suppuration is rare, but occasionally occurs.

The amount of the subcutaneous hæmorrhage which accompanies a contusion depends on the extent of the injury, the resistance offered by the tissues to the extravasated fluid, and the size of the injured vessels. In cases where a large area of tissue, not containing any important vessels, has been the seat of contusion the hæmorrhage will be diffuse, and will result in the production of a general **ecchymosis,** but where the injury is more localized, where the tissues are lax and yielding, or where a large vessel has been torn, the effused blood is collected into a mass, and forms a circumscribed extravasation, a blood tumour, or a **hæmatoma.**

In the case of a general ecchymosis the following changes occur in the extravasated fluid:—The fibrin clots, and causes a certain amount of induration. It is subsequently either organized and developed into new fibrous tissue, or, more probably, is absorbed by the leucocytes, which are soon exuded as the result of the injury. The serum and leucocytes escape into the

neighbouring lymphatics, and are thus removed. The red blood-cells disintegrate, and their colouring matter is diffused amongst, and stains, the surrounding parts. The hæmoglobin undergoes a series of changes, which finally result in the production of hæmatoidin, and the colour of the contused parts passes through various hues, the last being a pale lemon or citron. Crystals of hæmatoidin of this latter tint may be found for many months in the neighbourhood of a contused part.

The removal of the blood which forms a hæmatoma requires much more time than the disintegration of a simple ecchymosis. The coagulated fibrin surrounds the fluid portion of the blood, and is itself surrounded by newly formed fibrous tissue, which results from the irritation of the neighbouring parts by the mass of extravasated blood. New vessels are formed, and penetrate the dense wall which encloses the serum and corpuscles, and after a time the latter are slowly absorbed. The red blood-cells disintegrate, in the manner already described, but their colouring matter, instead of staining the tissues, as in a general ecchymosis, is diffused throughout the serum in which the cells are suspended, and thus the fluid contents of the hæmatoma become generally stained, and are often of a dark or tarry colour. If the serum is now absorbed, the fluid contents of the blood-cyst become thickened and inspissated, but if absorption does not occur, then the hæmoglobin gradually undergoes a series of changes which result in its loss of colour, the formation of hæmatoidin, and the production of a cyst which may contain an almost clear fluid. Such a condition as this is more often seen in hæmorrhages into the brain or the arachnoid cavity than elsewhere.

In other cases, again, the swelling caused by the blood-tumour never subsides, and a permanent hard lump may persist, which, on section, is found to be composed of fibrous tissue. The blood-clot is said to have become organized, but the exact manner in which

this organization takes place does not differ from that about to be described as occurring in the internal coagula of injured vessels.

Lastly, where the parts have been so injured that suppuration ensues, the extravasated blood tends to decompose. It becomes mingled with the products of suppuration, and together with them is discharged.

CHAPTER XXII.

HÆMORRHAGE AND INJURIES OF VESSELS.

HÆMORRHAGE is the escape of blood from the vessels within which it should normally remain. The escape may be due to either disease or injury, but it is with the latter alone that we are at present concerned.

If a wound be inflicted on almost any part of the body, bleeding results, but in the very large majority of cases the flow of blood is arrested without recourse to any artificial means, and it is only when some large vessel is opened or the patient is a "bleeder" that death ensues from loss of blood and syncope.

It is well known that blood tends to coagulate when no longer in contact with the endothelium of a healthy vessel, and, where nothing but small capillaries and arterioles have been wounded, the coagulation of the blood is alone sufficient to plug the apertures in the vessels, and to arrest the flow. But where larger arteries have been wounded, and the loss of blood is great, changes occur in the injured vessels themselves which help to bring about what is always the final means of stoppage, namely, the coagulation of the blood.

If an artery be cut across, it immediately **retracts** by virtue of its elasticity, and, by thus retracting, its bleeding orifice tends to be covered up and compressed by the tissues amongst which it is placed; the flow of blood is thereby diminished, and coagulation is

favoured. Another effect of injury to a vessel is **contraction.** This is not the result of elasticity, but of muscular action which is brought into play by both the injury and the exposure of the muscle-coat. So greatly is the lumen of a vessel diminished by this means that, in small arteries, the blood-flow may be entirely arrested by it alone.

It has already been said that the whole artery retracts within the surrounding tissues, but, in addition, the internal and middle coats, which are more elastic than the outer, retract yet more, and, by curling in towards the lumen, still further arrest the blood-stream.

Lastly, the more blood the patient loses the more coagulable does the remaining blood become, and the weaker is the heart's action and the blood-stream.

In these various ways, therefore, the blood-stream is weakened in cases of wounds of large vessels, but it must be distinctly borne in mind that each and all tend to one end, namely, the coagulation of the blood. If the latter did not occur, all the other events would be useless, and it is by the formation of a clot in the tissues outside the wounded vessels, the so-called **"external coagulum,"** that the bleeding is **temporarily** arrested.

This external clot is, then, but a temporary expedient; it is placed at the end of the bleeding vessel until a sufficient amount of time has elapsed for the artery to be permanently sealed, and, by the time this result has been attained, the external coagulum is undergoing absorption, and is subsequently entirely removed.

The **permanent** occlusion of the injured vessel is accomplished by a process of plastic inflammation, *i.e.*, by an exudation of inflammatory products, and a subsequent organization of the latter into fibrous tissue. Soon after the external clot has been formed *bleeding* has ceased, the ordinary phenomena of

inflammation make their appearance at the injured part, the cut ends of the injured vessel as well as the surrounding tissues become swollen and more vascular, exudation of inflammatory products results, and within a few hours the end of the cut vessel may be found embedded in a small mass of lymph. This lymph very shortly becomes vascularized by the formation of new blood-vessels from the vasa vasorum of the injured artery, and finally undergoes organization into fibrous tissue in a manner precisely similar to that which occurs in the healing of a wound by first intention. In this way the coats of the artery become matted to one another and to the sheath, and the whole end of the cut vessel is plugged by a firm mass of fibrous tissue continuous with the scar tissue of the wounded cutaneous surface.

At the same time that these changes are in progress, the blood in the injured vessel also clots, and the clotting extends a little way up from the seat of injury, never reaching beyond the origin of the first large branch given off above the wound. This clot, in contradistinction to that outside the vessel, is called the **internal coagulum**, and much more importance has been attached to it as a means of permanent occlusion than it deserves. The internal coagulum owes its origin to either the stopping of the blood-stream or to the proximity of the inflammatory exudation, for blood always tends to clot where the tissues are inflamed. The following changes occur in the clot after its formation :—

At first it is of a dark-red colour, and not at all adherent to the vessel-wall. In a few days it becomes of a lighter hue, and adherent to the artery ; gradually it becomes white, firm, and fibrous, and, in the process, shrivels in all its diameters. Finally, it becomes in part detached from the walls of the artery, and remains attached by its base alone to the fibrous tissue, which by this time plugs the end of the vessel.

If sections be made of the clot and of the artery which contains it during this process of organization, the following changes will be observed:—

At first the section shows nothing but red blood-cells entangled in a network of fibrin. Within a day or two these red blood-cells have all disintegrated, and leucocytes in greatly increased numbers are now seen. By the third or fourth day newly formed vessels penetrate into the clot from the neighbouring vasa vasorum, and from these an increased supply of leucocytes is derived. By the eighth or tenth day the whole clot is formed of leucocytes, which have displaced and destroyed the original clot and its red blood-cells, and are already undergoing organization into fibrous tissue. The newly formed vessels now shrink and disappear, the young fibrous tissue of the clot also shrinks, and, finally, a firm fibrous plug is all that remains of the internal coagulum.

Of what use, then, is the internal clot? It acts as a buffer, and prevents the rush of blood, which would otherwise tend to wash away the exuded lymph from the cut end of the vessel. It further tends to act as a permanent plug, and although of itself it would be quite insufficient to stop the forcible blood-stream in a large vessel, it is yet of some service in this respect.

CONTUSION OF ARTERIES.

Contusions of arteries may either set up inflammatory changes in the vessel without any definite injury being produced, or may cause a laceration of the internal and middle coats without tearing the external coat or the sheath. In the latter case the effects of the contusion are precisely the same as those produced by the application of a ligature, and the inner coats alone give way, on account of their more brittle nature. The torn coats curl in towards the lumen, and obstruct the blood-stream. Very

soon after the injury, coagulation of the blood commences at the injured spot, and the artery is gradually occluded both by the coagulated blood and, later on, by the formation of fibrous tissue produced for the repair of the damaged vessel. The condition of the limb below the seat of injury is exactly the same as it would be after ligature—cold, white, and pulseless. If the collateral circulation be sufficient to keep it alive, all will go well; if not, gangrene will ensue. Unfortunately, however, cases of partial laceration of an artery are seldom uncomplicated. The injury which damages the vessel is very likely to implicate its accompanying veins, and, if the circulation in the latter be also arrested, the chance of the occurrence of gangrene is greatly increased.

RUPTURE OF ARTERIES.

Complete subcutaneous rupture of a large artery is an accident of rare occurrence, and is more frequently seen in the popliteal and brachial than in any other vessel. The immediate result of complete rupture is the rapid extravasation of blood into the neighbouring soft tissues. Forcibly driven by the heart's action, the blood may be propelled to considerable distances along the fascial planes, and the whole limb becomes livid, swollen, pulseless, and cold. At first the swelling situated over the injured vessel pulsates, but, as the parts become more and more filled with blood, it is impossible for the heart to distend them further, and pulsation ceases. If nothing be done, gangrene will ensue, not only because the arterial flow is interfered with, but also because the extravasated blood causes pressure on the veins, and so prevents the return of the venous blood. It is of the utmost practical importance to recognize this latter fact, for if any attempt were made to treat the case by ligature of the artery above, as though it were one in which

the effused blood was in a definite sac, gangrene would inevitably ensue.

TRAUMATIC ANEURYSM.

A traumatic aneurysm is a "tumour containing blood communicating with the cavity of an artery," and resulting from an injury.

Traumatic aneurysms may be caused either by open wounds or by subcutaneous lacerations of an artery. In the former case the vessel is usually opened by a puncture with a sharp instrument, which is at once withdrawn. Hæmorrhage immediately ensues, but is arrested by pressure. The pressure, although sufficient to prevent the egress of blood from the skin-wound, does not suffice to prevent it from slowly leaking out of the wounded artery. A collection of blood is thus formed in the surrounding tissues, and these, being irritated by its presence, become matted and condensed by fibrous tissue. By this condensation, the further extravasation of blood is prevented, and an "aneurysmal sac" is formed, which soon becomes thickened and strengthened by coagulation of some of the blood within it. It is immaterial whether the original hæmorrhage be arrested by artificial pressure or by the resistance offered to the escape of blood by the muscles and fasciæ through which it flows.

In other cases an artery is subcutaneously torn or otherwise injured without any skin-wound being caused—*e.g.*, in fractures or dislocations, as well as, more rarely, in simple contusions or strains. Under these circumstances, as in punctured wounds, the resistance offered by the surrounding parts is often sufficient to prevent a wide extravasation of the blood, and the latter becomes limited by condensation of the soft parts, and by clot, in the same way as in the former case.

Another mode of formation of traumatic aneurysm *has been* described, but is of somewhat doubtful *rrence.* In punctured wounds of arteries which

have healed, the resulting scar is supposed to become distended by the blood-pressure, and an aneurysmal sac is thus formed by dilatation of the vessel at the seat of injury.

The limitation of the flow of blood by formation of the sac is to be regarded as the first step towards the healing of the injured artery. If no sac were formed, gangrene would ensue, but, the escape of blood having once been limited, the tendency to a natural cure is very considerable, and any aid afforded by rest and artificial pressure is most likely to bring about a gradual filling up of the sac by the deposit of laminated fibrin from the flowing blood, and to result in the subsequent occlusion of the injured vessel. In other cases the aneurysm increases, and by its pressure on the vessels may lead to gangrene of the limb. The same result may also be brought about by the giving way of the sac and the escape of its contained blood into the neighbouring parts.

ARTERIO-VENOUS ANEURYSM.

An arterio-venous aneurysm is an abnormal communication between an artery and a vein. There are two varieties. In the one, the communication between the two vessels is direct; in the other, the blood passes through an aneurysmal sac placed between the communicating trunks. The first variety is called an **aneurysmal varix**; the second, a **varicose aneurysm.**

Arterio-venous aneurysms are most usually the result of punctured wounds. They are generally situated on the limbs, and the communicating vessels are most frequently, in the case of the upper extremity, the brachial artery and the median basilic vein; in the lower extremity, the superficial femoral artery and its accompanying vein.

They are produced as follows:—A puncture is made by some sharp, narrow instrument, which passes *through one vessel* and opens the other. External

hæmorrhage is arrested either by artificial means or else by the resistance offered by the surrounding parts. The blood flows in the direction of the least resistance, and this, in the case of the artery, is frequently into the wounded vein. In many instances the wounded vessels become adherent by the inflammatory effusion which is poured out for their repair, and the blood continues to pass directly from the one into the other —aneurysmal varix.

In other cases a traumatic aneurysm is formed between the artery and the vein, and through this the blood circulates in its transit between the vessels—varicose aneurysm. Occasionally the arterial blood escapes, not only into the vein, but also into the surrounding tissues. The quantity effused may be sufficiently great to endanger the vitality of the limb.

Very rarely, arterio-venous aneurysms are formed independently of injury, and sometimes result from the opening of an ordinary pathological aneurysm into a neighbouring vein.

The two forms of arterio-venous aneurysm are not equally serious. An aneurysmal varix often does not tend to increase in size, whilst a varicose aneurysm pursues the course of any untreated aneurysm, and tends to increase.

In either case, the veins below the communication become tortuous, distended, and thickened, whilst the arteries above it tend to become, not only dilated, but thinned to such an extent that their ligature, if attempted after the lapse of years, is extremely likely to be followed by secondary hæmorrhage. The distended veins pulsate almost as forcibly as do arteries, and the finger placed upon them at once detects a well-marked thrill. Over the seat of communication a loud, continuous, humming bruit is always heard, which may be propagated for a considerable distance along the limb.

The chief danger of arterio-venous aneurysm is *rupture and* hæmorrhage. In some cases, indepen-

dently of such an accident, the use of the limb is much interfered with.

ON THE CHANGES PRODUCED IN THE VESSELS BY THE VARIOUS METHODS EMPLOYED FOR THE ARREST OF HÆMORRHAGE.

All the methods of treatment employed for the arrest of hæmorrhage aim at one object, namely, its temporary arrest. By none of them can the vessel be permanently occluded; the most that ligature, torsion, acupressure, &c., can do is to take the place of the external clot, and arrest the hæmorrhage for a sufficient length of time to allow of the permanent closure of the injured artery.

Pressure acts mechanically, by obliterating the lumen of the injured vessel, and so preventing the further escape of blood.

Acupressure is only another means of applying pressure.

Styptics induce the formation of an external clot.

Cold causes contraction of the cut artery and a narrowing of its lumen.

Ligature.—When a round ligature is applied to a vessel and tightly tied, the internal and middle coats, being brittle, are cut across, and the external one, being tough and resistant, is drawn in by the ligature and obstructs the flow of blood. The *material* of which the ligature is composed exercises no influence on the behaviour of the vessel which is tied, but the *width* of the ligature is of importance. If it is round and narrow, the inner coats are certain to be cleanly cut. If broad and flat, the coats may not be cut at all, but may all be drawn together, as is the external coat alone when narrow ligatures are used. The permanent closure of the vessel by the exudation and organization of plastic lymph, and the formation and organization of an internal clot, does not differ

from the process already described in dealing with the natural arrest of hæmorrhage.

FIG. 29.

Artery soon after Ligature, showing the inner and middle coats retracted.

FIG. 30.

Artery filled with an Internal Clot.

FIG. 31.

Artery with Shrunken Internal Clot, and orifice sealed by fibrous tissue.

If the ligature be of soft animal tissue, such as catgut, and, further, if it be aseptic, it will not act as a foreign body with respect to the artery which it encircles, and therefore suppuration will not ensue. If, however, the ligature be of silk or hemp, and is not rendered aseptic, then so long as it remains in contact with the vessel-wall inflammation will continue, suppuration will ensue, the artery-wall will ulcerate, and gradually the ligature will cut through the external coat and be cast off.

Torsion.—In torsion, the end of the cut artery is seized and twisted several times transversely to its long axis. The result of this treatment is the rupture of the internal and middle coats, as by the application of a ligature, and the twisting up of the external coat so as to form a sort of plug at the end of the torn vessel. Sometimes this twisted external coat sloughs, *on* ' of the interference with its blood-supply,

but this is not usually the case. The permanent closure of the vessel occurs in the manner already described.

RECURRENT AND SECONDARY HÆMORRHAGE.

Bleeding which re-commences after having been once arrested is called either recurrent or secondary. The term recurrent is sometimes limited to the hæmorrhage which occurs within twenty-four hours of injury, but the definition is purely arbitrary. Secondary hæmorrhage is most common during the first fortnight after injury, but may occur at any time before the wound is healed.

There are three main causes of secondary hæmorrhage, using the term to include the recurrent variety —first, **accident**; second, **unhealthy conditions of the wound**; third, **disease of the vessels.**

1. The accidental causes include such things as the use of a piece of bad ligature, which softens and gives way too soon; the overlooking of a wounded vessel, which does not bleed at the time the wound is inflicted, either because it contracts from exposure, or else because the patient is faint; the tying of a ligature badly, so that the knots slip; an accidental contusion of the wounded part, and the displacement or tearing open of recently formed clot or inflammatory exudation. If in any of these ways the ligatures which have been employed for the temporary arrest of hæmorrhage are displaced before the artery is permanently sealed, hæmorrhage will occur.

2. So long as a wound is healthy, and is either healing by first intention or by granulation, there is little fear of secondary hæmorrhage. The condition of the wound may be taken as the index of the condition of the vessels and their contained clots. If the former is healing well, it is pretty certain that the ends of the arteries are being firmly plugged by fibrous tissue, and their internal clots are undergoing organiza-

tion. If, however, the wound is sloughy, or the seat of erysipelas or other septic inflammation, then it is exceedingly probable that reparative processes are not progressing favourably in the cut vessel, and that the clot is tending to disintegrate. It is evident that under these circumstances secondary hæmorrhage is likely to ensue, for not only may there be a failure in the organization of the inflammatory products, but the ends of the vessels themselves may be involved in the destruction, and may slough or become so much softened that the ligatures which encircle them may cut through. Further attempts at securing the artery may be thwarted by the fact that the softened vessels will not admit the application of a ligature, however carefully applied.

3. A diseased condition of the injured vessels predisposes to secondary hæmorrhage in two ways. First, when tied, the ligature is liable to quickly cut its way through the softened wall; or, when twisted, the twisted end is liable to slough. Secondly, on account of their unhealthy condition, the reparative processes which ensue upon injury, and which normally seal a healthy vessel, are liable to be themselves of an unhealthy nature, and the inflammatory products either do not develop into fibrous tissue at all or do so only very slowly.

Injuries of veins.—Wounds of veins frequently heal without occlusion of the vessel, and, if clean cut, without any apparent cicatrix. A wounded vein heals more readily than a wounded artery, on account of the much more feeble blood-stream in it. The mode of healing is identical with that met with in the other soft tissues, namely, by plastic inflammation, with a consequent exudation and subsequent development of lymph into fibrous tissue.

AIR IN VEINS.

If air be mingled with the venous blood, it prevents *the proper* circulation of the latter through the lungs,

obstructs the right side of the heart, and may cause death.

A wound in a vein does not permit the entrance of air except under certain conditions. If under ordinary circumstances a vein be incised, either the blood rapidly escapes from it or the atmospheric pressure causes its collapse. If, however, a vein be held open—*e.g.*, if in removing a tumour traction be employed at a time when a venous trunk is wounded, and especially if the wounded vein be near to the thorax and its contained blood is brought under the influence of the suction produced by deep inspiration—then air is liable to pass with the blood-stream to the right side of the heart. The entrance of air is usually accompanied by a hissing or gurgling sound, and is immediately followed by urgent dyspnœa and laboured cardiac action. Such an accident most frequently occurs in operations at the root of the neck, where the veins are large, are close to the thorax, and are more or less held open by the deep fascia.

CHAPTER XXIII.

FRACTURES.

A FRACTURE is a solution of continuity of a bone. If the broken ends of the bone are not exposed to the external air through the medium of a wound, the fracture is said to be a **simple** one. If the reverse is the case, the fracture is **compound.**

A **comminuted** fracture is one in which the bone is broken into more than two pieces.

A **complicated** fracture is one in which the fracture is complicated by some injury to important neighbouring structures—*e.g.*, the tearing of a main artery, extension into a neighbouring joint, dislocation of the fractured bone, &c.

Again, the direction in which the line of fracture traverses the bone supplies the means for further classification. Thus, a **transverse** fracture is one in which the bone is broken at right angles to its long axis; an **oblique** fracture, where the line of fracture is oblique. Simple transverse fractures are most common in children, and are usually accompanied by but little displacement.

UNION OF SIMPLE FRACTURES.

The fracture of a bone is followed by extravasation of blood, as in the case of injury to any other vascular structure, but here, as elsewhere, this effused blood takes no part in the healing of the injured tissue, and is itself completely absorbed in the manner already described in the chapter on Contusions.

The way in which a fractured bone is united differs in no essential particular from the healing of a flap wound by first intention, and, like the latter, is the result of a process of plastic inflammation set up by the injury. Soon after the fracture, the ends of the broken bone become hyperæmic, exudation ensues, new blood-vessels form, and the neighbouring bone is softened. The medullary canal, the space between the broken ends, the torn periosteum, and the surrounding soft tissues are thus filled with an interstitial granulation tissue of precisely the same nature as that which joins the flaps in the case of wounds of soft structures, but which in the case of bone is called **callus.**

In the chapter on Inflammation it has already been said that suppuration is caused either by persistent irritation or else by the presence of septic material, and in simple fractures neither of these causes is usually found. Suppuration, therefore, is scarcely ever seen, and the inflammatory process set up by the injury stops short at the production of a sufficient amount of new material to unite the broken ends, and a sufficient softening of the osseous structure to ensure their proper welding together.

Of the inflammatory new formation, or callus, there are two varieties: the one is called "**definitive**" or **permanent**; the other, **provisional** or **temporary.** The definitive callus is that which lies between the fractured ends themselves; the provisional is found both within the medullary canal and outside the bone, beneath and around the periosteum.

If the callus be examined at various times during the union of fractures, it will be seen that it undergoes development into fibrous tissue just as does the granulation tissue in the healing of soft parts, but in the case of bone, on account of the influence exercised on all inflammatory products by the mother tissue, a further development into true bone occurs, in exactly the same way, as in a wound of a tendon, the inflam-

matory new formation, although at first only formed into fibrous tissue, is subsequently developed into tendon. Occasionally in man, and commonly in animals, the developing callus passes through a cartilaginous stage.

The amount of provisional callus that is formed depends on the amount of movement to which the broken bone is subjected, and this is just what might

FIG. 32.

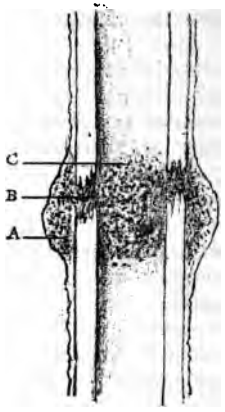
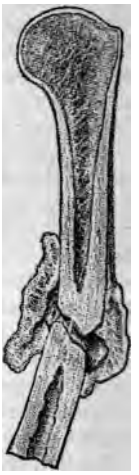


Diagram of a Fracture undergoing repair. A, External callus beneath the periosteum. B, Intermediate callus. C, Internal callus.

FIG. 33.



A Fractured Humerus three weeks after injury. The external and internal callus are ossified, but the intermediate callus has not yet been developed into bone.

be expected, considering that movement is likely to keep up the inflammatory process, and, as a consequence, to increase the amount of inflammatory exudation.

The callus which is first developed into bone is the provisional callus, and, in consequence, the broken

ends become fixed by a mass of bone which encircles them, and by another mass within, which, passing right through the medullary canal of each fragment, greatly assists in keeping the ends in good apposition. Where, however, this apposition is maintained by artificial means, such as splints, but little provisional callus is produced. After some weeks the definitive callus is formed, and from this time that which is temporary is gradually removed. Its total removal is necessarily the work of time, and the more of it there is the longer its removal will occupy. In consequence, it is sometimes many months, perhaps a year or more, before its obliteration is complete.

UNION OF COMPOUND FRACTURES.

A compound fracture may, and often does, unite in precisely the same way as a simple fracture. In other cases the process of union is complicated by suppuration.

Now, this is precisely what occurs in wounds of the soft tissues. Frequently the wound unites by first intention, *i.e.*, without suppuration; in other cases suppuration and union by granulation result. The cause of the suppuration in the wounds of the soft tissues and of bones is identical. It is almost always the result of contamination by septic particles conveyed to the wounded surface by the medium of the air; more rarely, mechanical irritation alone produces suppuration.

If, therefore, in the case of a compound fracture the wound is closed, and heals by first intention, the fracture will usually do the same, and a similar result may be obtained by dressing the wounded surface with antiseptics of various kinds, which prevent the influence of septic contagion.

If, however, the wound is not closed, and becomes septic, then the inflammatory process will progress, an excess of effusion will result, pus will be formed, and the granulating ends of the bones

will be exposed. Union will in time take place, at first in exactly the same way as in granulating wounds of the soft parts, namely, by the growing together of the two granulating surfaces, and subsequently by the formation of bone in the young fibrous tissue.

In some cases of compound fracture portions of the bone die, or necrose. Such a result is most frequent when the broken bone is comminuted and the fragments are detached from their vascular connections. When the bone dies, suppuration always occurs, and union will be delayed until the necrosed bone has been separated and cast off. The subject of necrosis is dealt with at greater length in the chapter on Diseases of Bone.

NON-UNION OF FRACTURED BONES.

Occasionally, fractures fail to unite by bone, and, although the broken ends may be more or less fixed by fibrous tissue, such cases are spoken of as **ununited fractures.**

The **causes** of non-union are various, but may be grouped into two main classes—first, local; second, constitutional. Of these, the former are the more important, and will be first considered.

The **local** causes of non-union are three:—(1) want of apposition; (2) want of rest; (3) want of blood-supply.

Want of apposition is probably the commonest cause of non-union. It may be brought about in various ways. In many cases the contraction of muscles inserted into the fractured bone separates the fragments, as is well seen in fractures of the coracoid or olecranon processes, of the condyles of the humerus, of the neck of the femur, &c. In other instances portions of muscle may be caught between and keep apart the broken ends. In the case of transverse fracture of the patella, more causes than one are in action, for the broken ends are separated both by the contraction of the quadriceps extensor and, to a

great extent, by the effusion of fluid into the knee-joint, which floats the fragments up and keeps them apart.

Want of rest is of less importance than want of apposition, but it occasionally prevents bony union. If callus has been formed and is in process of organization, there can be no doubt that the recently formed fibrous and osseous tissue may be readily broken down by careless movement. It will, however, be again reproduced, and it is only when this breaking down has frequently occurred that bony union fails; for, in the large majority of cases in which a fracture remains ununited for want of rest, firm union will rapidly result from adequate surgical treatment.

Want of blood-supply is very seldom the sole cause of non-union. In fractures of the lower third of the humerus, the comparative frequency of non-union has been attributed to the fact that the line of fracture traverses the nutrient artery; and the failure of union of intracapsular fractures of the femur is also attributed to the scanty blood-supply to the head of the bone. It is more probable that the fracture of the humerus fails to unite from want of rest, and that of the neck of the femur from failure of apposition.

Interference with the circulation by *venous thrombosis* in the neighbourhood of the fractured bone is believed by many surgeons to play an important part in the failure of union of fractures. It is certainly true that, in cases of non-union, there is very frequently a persisting œdema of the injured extremity, and it is probable, though difficult to prove, that the thrombosis which causes the œdema may also prevent the union of the fractured bone.

Constitutional causes of ununited fractures.—Of all the constitutional diseases which tend to prevent union of fractures, **scurvy** is probably by far the most active, for it would appear, from the descriptions of authors who have had opportunities of watching cases of scurvy, that, so long as the patient

is suffering from this disease, fractures are very likely to remain ununited. After scurvy, **chronic nephritis**, in any of its various forms, appears to delay union more effectually than disease of the other viscera; and, lastly, it may be said that any disease which induces debility, and which perhaps, in addition, causes an alteration in the naturally healthy bones themselves, will tend to delay, if not to prevent, union. Causes such as these, however, act in a manner which is very easy of comprehension. If the patient be in an enfeebled condition, he is little likely to repair any injury with rapidity, and, in consequence of his lowered vitality, the inflammatory process does not result in the production of a sufficient amount of callus, or a sufficient softening and welding together of the fractured bones.

Changes in the bones in ununited fractures.—If a fractured bone fails to unite, the broken ends may be either merely held in apposition by fibrous tissue, or a false joint may be formed.

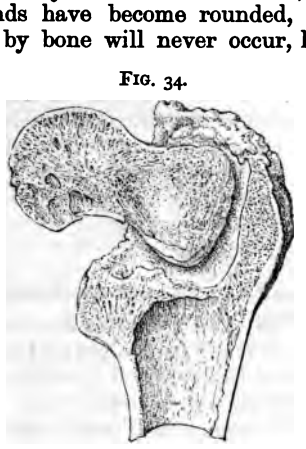
The inflammatory effusion, which has been poured out after the injury, undergoes organization into bone, in some parts at least, and, as a result, the medullary canal is occluded and the fractured ends become rounded off and smooth. Where the fragments are widely separated, there may either be no uniting material at all or else it may be so thinned and stretched as to deserve the name of "**membranous union.**" Where the uniting medium is stronger and denser, the union is said to be "**fibrous**" or "**ligamentous.**"

In some instances when the ends of the fractured bone have been placed in apposition, and move on one another, a **false joint**, or **pseudarthrosis**, results. In such cases the fragments are enclosed in a kind of capsule of fibrous tissue, the inner surface of which becomes, in time, smooth and polished, and secretes a serous fluid to facilitate movement. The ends of the bones become variously altered in shape, and adapted

to one another, but the false joint is either a simple hinge or else a ball-and-socket joint. The latter condition is well shown in the accompanying drawing, from a case of ununited fracture of the femur.

When a false joint has been formed, or when the fractured ends have become rounded, smooth, and hard, union by bone will never occur, however long

FIG. 34.



Ball-and-socket Joint formed after Intra-capsular Fracture of the Neck of the Femur.

the bones are kept in apposition and at rest. The opportunity for union has passed by, and the chance has been missed. When the bones were softened by recent inflammation and embedded in recent granulation tissue, then was the time for union to take place, but if, after the inflammatory products have become organized, and the bones hardened, union has not resulted, it can never take place, unless by artificial means fresh inflammation is excited.

SPONTANEOUS FRACTURES.

When a bone breaks from the application of an amount of violence which would not damage any healthy bone, the fracture is said to be "spontaneous."

The violence may be extremely slight, and almost unnoticed by the patient. A diseased state of the osseous structure predisposes to such fractures. The bone may be simply in an advanced state of senile decay and degeneration, or, on the other hand, may be the seat of malignant disease. In addition to these causes, it has recently been pointed out that in tabes dorsalis the bones are sometimes very brittle, and may break spontaneously. Both mollities ossium and rickets may cause the bones to become so much softened that they break on the application of the slightest violence, and, more rarely, the bones of a limb which has been kept at rest for very long become softened to a similar extent. In cases of spontaneous fracture, failure of union by bone is common.

SEPARATION OF EPIPHYSES.

The separation of an epiphysis is an accident which necessarily occurs only in children and young subjects. In this form of injury, both the epiphysis and the epiphysial cartilage are separated from the diaphysis, the epiphysial cartilage itself being seldom torn. The injury is repaired in the same way as is a fracture, and it is exceptional to find that, as a result of the separation of the epiphysis, the subsequent growth of the bone is impeded. Sometimes, however, growth is partially arrested, and the affected limb may thus become shorter than its fellow.

Both congenital syphilis and scurvy rickets predispose to separation of the epiphyses.

CHAPTER XXIV.

DISLOCATIONS.

The term dislocation simply implies a displacement, but, used without any qualifying adjective, is taken to mean the displacement of one articular surface from another with which it is naturally in contact.

Dislocations are commonly the result of violence applied to a limb at a distance from the joint which is the seat of the displacement. Thus, whilst a fall on the shoulder or hip may cause a fracture, dislocation of these joints is usually produced by violence applied to the arm or leg. Dislocations are also caused by irregular muscular action; *e.g.*, the lower jaw is frequently displaced by a sudden contraction of the muscles of mastication at a time when the mouth is opened, as in the act of yawning or laughing. The patients in whom dislocations are most frequently met with are young and muscular adults, for in old people the bones yield rather than the ligaments of the articulation, and in children the joints are so supple that dislocations are not readily produced.

It is evident that in the production of a dislocation some of the soft structures around the damaged joint must be injured, and thus we find that the capsular and other ligaments are torn, together with the surrounding muscles and tendons, to a varying extent.

CHANGES IN AN UNREDUCED DISLOCATION.

If the dislocation be not reduced, certain changes occur in the articular bone and the surrounding

soft tissues which are of considerable practical importance.

The immediate results of the injury are a synovitis of the damaged joint and an effusion of blood into it and the tissues around; both of these rapidly subside. The torn ligaments, muscles, and tendons soon undergo repair by fibrous tissue, and become matted together by the formation of "adhesions" in such a way that various important structures, such as vessels and nerves, become adherent to the muscles and tendons amongst which they lie, and are dragged upon by any force which exercises traction on the latter. In consequence of this, if violent efforts are made to reduce the displaced bone after the newly formed adhesions have become firm and strong, either the vessels or nerves to which they have formed attachments may be ruptured.

The cartilage of the dislocated bone undergoes degenerative changes which result in its metamorphosis into fibrous tissue, and, if it rests on another bone, further changes may ensue which terminate in the production of a false joint. Take, for instance, the case of a subcoracoid dislocation of the humerus. The head of the latter bone will gradually alter in shape, and become flattened, and the neck of the scapula on which it rests will be hollowed out. In each bone the alteration in shape is the result of pressure, for in all tissues continuous pressure produces atrophy. Around the newly formed depression in the scapula a rim of new bone is then formed, for the irritation produced by the presence of the displaced humerus causes a formative periostitis in the neighbouring bone. The same irritation causes the condensation of the neighbouring soft structures, and by this means a fibrous capsule is formed, and the false joint is thus completed. Meantime, changes have been in progress in the glenoid cavity, its cartilage has become fibrillated, and from its floor a new growth of

fibrous tissue springs which gradually completely fills the cavity itself.

At first the patient has but little use in a limb one of the chief joints of which is the seat of an unreduced dislocation. Gradually, however, it becomes less painful and stiff, and, after many months, the part is frequently restored to much of its former power, for the muscles accommodate themselves to the altered relations of the neighbouring structures, and, as the new joint is formed, and the inflammation set up by the injury subsides, pain on movement slowly passes away.

A consideration of the changes just described will show at once that, apart from the dangers of reduction of old dislocations, there comes a time when replacement of the dislocated bone is no longer possible on account of the fixation of the bone in its new position, and the filling up of the articular cavity which it formerly occupied.

CHAPTER XXV.

REPAIR OF MUSCLE, TENDON, CARTILAGE, AND NERVES.

REPAIR OF MUSCLE.

MUSCLE is a tissue which in man is never reproduced, and in animals only to a very slight extent. Consequently, in wounds of muscle the divided portions are never united by newly formed muscle, but always by fibrous tissue, which is produced in the manner already described in dealing with union of wounds. The separation of the divided muscle during the healing process naturally influences the amount of scar tissue formed, and the greater the separation the more powerless is the muscle after cicatrization has been completed. It is therefore of importance to maintain as good apposition as possible during the healing of the wound.

REPAIR OF TENDON.

A divided tendon placed under favourable conditions unites by tendon in the following manner:—Plastic exudation takes place into the tendon-sheath and into the cut ends of the tendon themselves, the exudation being vascularized, and subsequently developed into fibrous tissue, in exactly the same way as is the granulation tissue of a flap-wound. After this, a further development into tendon tissue occurs, and the previously irregular masses of fibrous tissue are gradually shaped into longitudinal bundles, with

connective-tissue cells placed between. Finally, the tendon, which is at first adherent to its sheath, is gradually separated, and again becomes free and movable.

If the ends of the divided tendon be allowed to retract to considerable distances, or if much suppuration occurs, the tendon will not unite as above described. On the contrary, its ends will become adherent to the surrounding parts, and the use of the muscle which is inserted into it will be lost.

REPAIR OF CARTILAGE.

Cartilage, like muscle, is not reproduced in cases of injury. The breach is repaired by fibrous tissue.

INJURIES OF NERVES.

If a nerve is divided, certain changes occur in both its peripheral and proximal extremities, and also in the structures to which it is distributed.

The proximal end of the divided nerve becomes swollen and bulbous, the enlargement continuing to increase for several weeks after section. The bulb is oval in shape, about two or three times as thick as the divided nerve-trunk, and about twice as long as it is broad. It is tougher than normal nerve tissue, and adherent to the structures amongst which it is placed. On section, it presents a fibrous appearance, but bundles of nerve tubules can be seen embedded in its substance. On microscopical examination, it is found to consist of numerous young nerve-fibres lying in a matrix of fibrous tissue.

The peripheral end of the divided nerve undergoes atrophic and degenerative changes at the same time that the bulb is being formed. The myelin breaks up, collects in globules in the nerve sheath, and is finally entirely removed. The axis-cylinders disintegrate, and in the course of a few weeks at the latest are completely destroyed. As a result of this

destruction, the peripheral end of the nerve is very perceptibly diminished in size.

The manner in which a severed nerve unites is variously described by different authors. It is probable that the following description is correct.

After undergoing the degeneration just described, the peripheral end regenerates. The axis-cylinders are first formed from the proliferated nuclei of the sheath of Schwann; around these a myeline sheath is subsequently developed, and, if the peripheral end is in contact with the proximal extremity, the young nerve fibres formed in the bulb of the latter unite with the newly formed axis-cylinders in the lower end, and the nervous functions are restored. It must, however, be borne in mind that union will not occur unless the divided extremities are maintained in close contact, and, as nerves, like all other soft structures, are in a state of longitudinal tension, it is usually necessary to suture the cut ends in order to maintain the necessary apposition.

The structures to which a nerve is distributed suffer in various ways if the latter is divided.

The skin, in addition to losing its sense of touch, becomes glossy and shiny, ulcers may appear at the peripheral parts, and, occasionally, small portions of tissue slough. In the case of the hand, painless whitlows may form, and the nails may either be cast off or become fibrous and brittle, with exaggerated curvatures and transverse ridges and furrows. Immediately after section, and for a time which may extend to two or three weeks, the anæsthetic parts are hypervascular, and warmer than natural, on account of the division of the vaso-motor fibres. Very soon, however, this condition gives way to an abnormal coldness, and the loss of heat frequently amounts to five or ten degrees.

The joints supplied by the severed nerve are sometimes swollen and painful shortly after the injury; later on, they are often partly anchylosed.

The muscles are paralysed from the moment that the nerve is divided, and undergo an extremely rapid degeneration and atrophy. Faradic contractility is lost within a few days, and galvanic irritability in from three to six weeks. The muscle substance itself is the seat of fatty degeneration, and within two or three months of the injury the entire muscle is usually completely atrophied.

Notwithstanding the extent to which these so-called "trophic" changes may proceed, a complete restoration of function will result if the divided nerve becomes united at a subsequent period, and not only will sensation be restored, but atrophied and paralysed muscles will be renovated.

Division of a nerve is not always followed by degeneration of the peripheral end before union takes place, and, in animals at any rate, a "union by first intention" without antecedent degeneration has been described. Clinical experience tends to show that, although such union may, and does occasionally, occur in man, it is rarely seen, and, from the very nature of the process, opportunities for examining the recently joined nerve are very rarely forthcoming. A year or two sometimes elapses before sensation and motion are restored.

CHAPTER XXVI.

DISEASES OF ARTERIES. DEGENERATION AND ATHEROMA.

PRIMARY FATTY DEGENERATION.

Fatty degeneration may be either primary, or secondary to pre-existing inflammation. Primary fatty degeneration may affect any of the coats of a vessel, but is most common in the inner coat. Here it first attacks the endothelial lining, and the cells of the latter are gradually filled with granules of fatty matter; the diseased cells disintegrate and are cast off. The degenerative process sometimes extends over considerable areas, and is most commonly met with in the aorta. It may be distinguished from atheroma by observing that the degeneration is limited to the endothelial surface, and that the deeper parts of the inner coat are healthy. When fatty degeneration affects the deeper parts of the inner coat or the middle and external coats, the whole artery is liable to become greatly weakened, and where not supported adequately by the surrounding tissues, as in the brain, the diseased condition may lead to rupture and hæmorrhage; degeneration of the middle and outer coats is most common in the smaller arteries and arterioles. Fatty degeneration in all its forms is essentially a disease of late life.

PRIMARY CALCAREOUS DEGENERATION.

Calcareous degeneration of an artery may either be *secondary to* pre-existing inflammation, or may occur

primarily in vessels otherwise healthy. The subjects of primary calcareous degeneration are always past middle age; the vessels most frequently attacked are those of medium size, especially the tibials and the arteries at the base of the brain. The degeneration affects more particularly the middle coat, and the individual muscle fibres of the latter are gradually infiltrated with salts. The calcifying process, following the circular arrangement of the muscle fibres, causes the production of rings of calcareous material which are very typical of the primary form of calcareous degeneration. After a time both the inner and middle coats may become similarly diseased, and the whole vessel may be converted into a rigid and brittle tube. The circulation through a calcareous vessel is necessarily greatly impeded, and, occasionally, thrombosis may occur from the clotting of blood on the roughened inner coat.

FIG. 35.

Primary Calcareous Degeneration of the Femoral Artery, showing the rings of calcareous material which are formed in the muscular coat.

Fatty and calcareous degenerations frequently coexist in the same artery.

ACUTE ARTERITIS.

Acute inflammation of arteries never occurs idiopathically, and, when it has begun, shows no tendency to spread. If a vessel be injured, its coats will inflame, exudation will follow, and the artery will be occluded in the way already described in the chapter on Hæmorrhage. The most typical examples of acute arteritis, however, are supplied by vessels lying in the midst of

suppurating tissues. It is true that arteries offer very considerable resistance to the spread of inflammation, but, nevertheless, they are frequently involved in the process. The blood in the inflamed vessel clots, the artery-wall is softened by exudation, suppuration follows, and all the coats are gradually ulcerated through. In most cases no hæmorrhage ensues, for the vessel is already full of clot, and above the seat of suppuration it is thickened by plastic exudation. In some cases, however, and more particularly when the inflammatory process is a septic one, large portions of the artery slough, and, the clot being soft and disintegrating, and insufficient to arrest the flow of blood, copious hæmorrhage may result.

The lodgment of septic emboli in vessels is another cause of acute inflammation. In cases of ulcerative endocarditis, portions of fibrin infiltrated with the products of septic inflammation are liable to be detached and swept from the aortic valves into the blood-stream. Wherever they lodge they excite a destructive inflammation similar to that which is in progress at the place from which they have been derived, and, in consequence, the wall of the vessel is liable to become either merely softened by inflammation or else penetrated by ulceration. In some cases hæmorrhage results, but in many others the occlusion of the artery by clot prevents the escape of blood.

Acute inflammation of the aorta has been described by various authors. This form of inflammation, which is supposed occasionally to follow typhus fever, does not result in suppuration. There is said to be a gelatinous exudation into the inner coat, the endothelial surface of which may be roughened by deposit of fibrin. It is certainly of rare occurrence.

ATHEROMA, OR CHRONIC ARTERITIS.

Atheroma is not a degenerative, but an inflammatory process. A better name for it is chronic arteritis.

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cause slight swelling of the internal coat, which bulges towards the lumen of the vessel. Microscopical examination will show that exudation of inflammatory products has occurred, and the cellular tissue beneath the endothelium is seen to be the seat of a considerable collection of leucocytes. These cells have collected here, partly because the inner coat is the first to feel the effects of the undue tension, and partly also because, on account of the looseness of the sub-endothelial cellular tissue, there is more room for the inflammatory exudation to collect in this situation than in the middle and external coats. It is, however, quite erroneous to suppose that the latter tunics escape entirely. Such is not the case. On the contrary, cell exudation takes place into them also, and increases and extends as the atheromatous process progresses, so that the inflammation may extend beyond the outer coat and may involve the sheath.

It is probable that in some cases the inflammatory process undergoes resolution and the exuded cells are removed. Frequently, however, this does not occur, and the cells either undergo degenerative changes or develop into fibrous tissue.

Very frequently, indeed, the degenerative process predominates in the cell exudation in the inner coat, and for the reason that in this situation the leucocytes do not receive a sufficient blood-supply. It must be remembered that the vasa vasorum do not pass beyond the middle coat, that the inner coat is mainly nourished by a process of osmosis, and that such a process is only capable of nourishing a certain limited thickness of tissue. When, therefore, the blood-vessels which have been formed during the first stage of the inflammatory process shrink and disappear, the cell growth which they have produced is left without sufficient means of nutrition, and consequently degenerates. In most cases the degeneration is of a **fatty** nature, and the cell collection is gradually converted into a yellow, caseous mass.

The endothelium also undergoes degenerative changes which result in the destruction of its constituent cells. In consequence of this, the disintegrating caseous mass is exposed to the blood-stream, and by it is slowly washed away, the wall of the vessel being thus left roughened and partly destroyed.

In the meantime, the cells which have been exuded into that part of the inner coat which is in contact with the muscular tunic, as well as those which lie in the middle and outer coats, have undergone organization into fibrous tissue, and by this means the arterial wall is strengthened at the weak spot, the coats are matted to one another, and the artery in time becomes adherent to its sheath. For this reason, although the blood obtains an entrance into the coats, it does not separate them from one another, and form a dissecting aneurysm; neither, as a rule, is its force sufficient to rupture the diseased vessel. But, although fatty degeneration is the most common sequel of the cell exudation, it does not always occur, and, even when present, is frequently associated with other changes. Very frequently **calcareous** degeneration of the inflammatory products either takes the place of, or succeeds to, the caseation, and, in consequence, irregular plates of calcareous matter develop in the arterial wall. They present an altogether different appearance to the rings caused by primary calcareous degeneration of the muscle-coat, already described.

But, whilst degenerative processes are very common in the cells exuded into the inner coat, it must not be thought that development of fibrous tissue never results. It is probably much more common than is generally supposed, and very frequently, indeed, some attempt at the formation of fibrous tissue may be found occurring together with caseation, whilst, in some instances at least, the whole cell mass undergoes development, and the arterial wall is permanently thickened and indurated. The greater the

tendency to the formation of fibrous tissue, the less likely is the endothelium to perish.

To the naked eye, an artery which is atheromatous is at once seen to present a very irregular and lumpy inner surface, to be more rigid than natural, and, when cut across, to remain distended, and not to contract like a healthy vessel. Closer inspection will show that the endothelium is raised in numerous patches, and, through the lining membrane of cells, the subjacent material looks yellow or opalescent. The yellowish substance is caseous material lying beneath the endothelium, and is readily exposed by peeling away the latter. If fibrous tissue has been formed, the yellow tint is less marked, and the endothelium is more adherent.

FIG. 36.

An Atheromatous Artery. In the lower part of the specimen, the intima is irregular and rough. In the upper part, the intima has been destroyed, and a bulging of the other coats indicates the commencement of a sacculated aneurysm.

At a later stage, the artery is found to be distinctly roughened, the endothelium has perished, and the deeper parts of the intima, or even the muscle-coat, may be exposed to the blood-stream. Shreds of fibrin may adhere to the roughened spots, or definite coagula may have formed. When calcification has occurred, the artery is more than usually rigid, and irregular plates of calcareous matter can be both seen and felt in its inner coat. The sheath is more adherent than natural, and when rolled between the fingers the vessel feels firm and cord-like.

In consequence of the alteration in its structure, the circulation through an atheromatous vessel is

more or less impaired. The diseased artery is more rigid than natural, and, having lost its elasticity, it is unable to accommodate itself to the constantly altering requirements of the tissues for blood, and the parts to which its branches are distributed become ill-nourished, atrophied, or degenerated. Worse results than this may ensue, for the roughening of the inner coat may cause deposition of the fibrin from the flowing blood, and occlusion of the vessel by thrombosis may completely arrest the circulation.

SYPHILITIC ARTERITIS.

Syphilitic arteritis is characterized by the great thickening of the inner coat. It may occur at any time after inoculation, and, though most common in the cerebral vessels, is not confined to them, but affects the small arteries of any part which is the seat of

FIG. 37.

Syphilitic Disease of one of the Cerebral Arteries. The inner coat is thickened by fibrous tissue, and the lumen is much narrowed.

yphilitic inflammation, and is especially common in he neighbourhood of gummata.

Microscopical examination shows that there is a growth of granulation tissue in the inner coat, with the subsequent formation of fibrous tissue to such an extent that the intima may become three or four times as thick as the middle and outer coats. These latter also are the seat of some cell exudation, but never become greatly thickened. As the result of this formation of fibrous tissue, the lumen of the vessel is sometimes much narrowed, and in other cases the endothelium is so altered by the exudation beneath it that the blood clots on it, and the artery becomes occluded by a thrombus. Such interference with the cerebral circulation is liable to cause "softening of the brain." Some authors consider that similar arterial disease accounts for the degeneration and caseation of gummata. When syphilis attacks the larger vessels, it not infrequently leads to the formation of aneurysm.

CHAPTER XXVII.

DISEASES OF ARTERIES.
ANEURYSM.

An aneurysm is "a tumour containing blood, and communicating with the cavity of an artery."

The **causes** of aneurysm are practically those of atheroma, for pathological aneurysms, with which alone we are at present concerned, are almost invariably preceded by disease of the vessel. Therefore, laborious occupations, disease of the kidneys, and syphilis are amongst the most common of the accepted causes of aneurysms. The formation of traumatic aneurysms has already been described.

It is very easy to see how chronic arteritis may cause aneurysm, for the inflammatory process frequently weakens the vessel, and so favours its distension by the blood. In other cases it is the loss of elasticity rather than the weakening which brings about the aneurysmal dilatation, for, if the heart's action be sufficiently strong to dilate the rigid vessel, toughened by fibrous tissue, the artery will, in consequence of its loss of elasticity, remain dilated, and thus form an aneurysm.

In the presence of one of the above causes, the locality of an aneurysm is determined by local conditions. The aorta is more frequently implicated than other vessels, on account of the greater blood-pressure within it, whilst the slight arrest of the blood-stream at the point of bifurcation of any vessel *tends to the formation* of an aneurysm above such a

point. Again, vessels at the flexures of limbs are more liable to become aneurysmal than vessels in other situations, and for the reason that, in any artery which is diseased, sudden and forcible bending may cause injury to the brittle internal and middle coats.

The aneurysms that occur in children and young adults are most probably the result of the lodgment of emboli. The exact manner in which emboli cause aneurysms is yet a matter of dispute. According to one theory, the artery becomes dilated above the seat of embolism through the increase in the blood-pressure above the seat of plugging. This is most probably incorrect, for, were such an explanation true, aneurysms would develop with comparative frequency after ligature, whereas, although they may follow occlusion of the vessel by surgical means, they do so with extreme rarity, and are more frequently the result of a failure of the proper occlusion of the artery than of its obliteration. According to another theory, an embolus may cause aneurysm by setting up inflammatory changes in the vessel at the point at which it lodges. The inflammation may result either in the complete penetration of the artery by a process of ulceration, or else in softening of its coats and subsequent dilatation. All emboli do not act in this manner, and the production of an aneurysm in any given case is attributed either to the embolus being calcareous and rough, or else to its being derived from a heart affected with "ulcerative endocarditis," and consequently itself impregnated with the products of an *infective* inflammation.

Lastly, another possible cause of aneurysm must be mentioned. Suppuration around a vessel may so damage it that the coats may yield and an aneurysm form, or the artery may give way and rupture.

VARIETIES OF ANEURYSM.

An aneurysm consists of a **sac** and its **contents**. The sac is formed by the coats of a diseased vessel, its

sheath, and the surrounding structures, in varying proportions. The contents of the sac are fluid blood, clotted blood, and laminated fibrin.

Pathological aneurysms have been classified in various ways. The following appears to be one of the simplest:—

(1) Fusiform aneurysm.
(2) Sacculated aneurysm—
  (*a*) True;
  (*b*) False;
  (*c*) Diffused.
(3) Dissecting.
(4) Cirsoid.

The various forms of traumatic aneurysm have been already described in the chapter on Injuries of Vessels.

A fusiform aneurysm, or an aneurysmal dilatation, is a dilatation of a vessel in its whole circumference and for a considerable portion of its length. Such an aneurysm is oval in shape, and continuous at each end with the cavity of the vessel on which it has been formed. Its sac consists of the arterial coats in an atheromatous state, with a few shreds of adherent fibrin. It contains usually little else than fluid blood. Fusiform aneurysms are found on the large arteries alone, and far more frequently on the aorta than on any other vessel.

A sacculated aneurysm is a dilatation of an artery in a part only of its circumference. A **"true"** sacculated aneurysm is one the sac of which consists of all three coats of the vessel. A **"false"** sacculated aneurysm is one in which the internal and middle coats have been thinned away, so that, on section, the sac is found to contain the outer coat alone.

Considering that the chief cause of aneurysm is atheroma, it is evident that "true" aneurysms must be of rare occurrence, for the atheromatous process

itself usually causes destruction of some of the coats before an aneurysm commences.

FIG. 38.

A Fusiform Aneurysm of the Common Femoral Artery.

FIG. 39.

A Sacculated Aneurysm of the Popliteal Artery.

A diffused sacculated aneurysm is one in which the sac contains none of the coats of the vessel, but consists simply of the sheath, with condensed surrounding tissues and blood-clot. This form of aneurysm has also been called "consecutive."

A dissecting aneurysm is one in which the blood is contained in a sac formed within the wall of the artery itself, the blood generally passing down between the layers of the middle coat, and splitting the wall of the vessel for a greater or less distance. Such an aneurysm necessarily results from a destruction of the inner coat, for by this means *alone can the* blood obtain an entrance. The reason

why dissecting aneurysms are not of greater frequency is that, as a rule, the coats are matted to one another by fibrous tissue before the inner coat gives way. It is when this process of adhesion fails that a dissecting aneurysm is formed. Dissecting aneurysms occur on the aorta alone, and may progress in one of two ways. In the first place, the blood may burst its way through the intima, and may thus return to the cavity of the diseased vessel after a transit of some length through its walls. Secondly, it may burst through the outer coat, and, escaping into the surrounding parts, cause death by hæmorrhage.

The natural course of an aneurysm may be in one of two directions. It may progress, and cause the death of the patient, or may become spontaneously cured. Unfortunately, the former is infinitely the more common, yet it is of much importance to thoroughly understand the processes by which, independently of surgical interference, a cure may be promoted.

A fusiform aneurysm sometimes remains in an almost stationary condition for many years, and so long as it remains fusiform is little likely to kill the patient, unless, indeed, it do so by interference with the action of the heart. What usually happens is that, after a varying length of time, the dilated artery commences to yield more rapidly at one part of its circumference than in the rest, and thus from the fusiform aneurysm a sacculated aneurysm springs.

The sac of a sacculated aneurysm at first consists of some at least of the coats of the diseased vessel, although even from its commencement it receives support from its sheath and from the surrounding structures. As the sac increases in size from the constant pressure of the blood, the arterial walls become more and more thinned away, so that, although at first perhaps a true aneurysm, its inner and middle coats wear away and it becomes a false one. Later still, all its coats being destroyed, it is called "diffused" or "consecutive," the blood being

limited merely by the arterial sheath and the surrounding tissues. These latter undergo considerable changes, and become matted together by fibrous tissue into a firm, resistant mass. Were it not for the support thus accorded to the sac by the surrounding soft tissues and by the arterial sheath, the rupture of an aneurysm would occur at a much earlier period than is usually the case. This point is well illustrated by large aneurysms of the cerebral vessels, for the latter, receiving but little or no support from the tissues in which they lie, are never the seat of aneurysms of any size; the diseased vessel gives way instead of continuing to dilate.

In any case, when an aneurysmal sac no longer contains any of the arterial coats, and consists merely of the condensed surrounding tissues, it is very liable to increase with greater rapidity than before, and, inasmuch as the support it receives from its surroundings necessarily varies at different parts, it increases more rapidly in the direction of the least resistance. After a variable time it bursts, and is now called a **ruptured aneurysm.** The rupture may take place into the soft tissues of the part in which the vessel is placed, and, if the loss of blood be great, the rupture may be followed by such an amount of obstruction to the circulation that gangrene results. Sometimes the rupture takes place into a serous cavity, such as the pleura or pericardium, and then the escape of blood is at once both rapid and profuse. Sometimes, though comparatively rarely, an aneurysm reaches the cutaneous surface, and bursts there. If so, the hæmorrhage is not so sudden or profuse as would naturally be expected. On the contrary, days or weeks may pass before death results. During its growth an aneurysm spares no structure with which it comes in contact. The constant pressure of the sac causes atrophy of soft tissues and of bones alike, and thus, in the case of aortic aneurysms, the bodies of the *vertebræ,* the ribs, and the sternum may be in great

part destroyed. In popliteal aneurysms, the posterior surface of the femur is sometimes partially excavated, and the sac has been known to open into the knee-joint.

The pressure exercised by the aneurysm on the surrounding structures occasionally causes tolerably acute inflammation. This may progress to suppuration and sloughing, the sac may be opened, and profuse hæmorrhage may cause a speedy death.

SPONTANEOUS CURE OF ANEURYSM.

There are practically but two ways in which an aneurysm can become cured. The one is by the gradual filling of the sac with laminated fibrin, the other by the clotting of the blood contained within the sac. A clot composed of laminated fibrin is often called an "**active clot,**" whilst that formed by the coagulation of the blood contained in the sac at any one time is called a "**passive clot.**" In either case, the sac having become filled, the clot extends into and occludes the diseased vessel from which the aneurysm springs. All treatment, medical and surgical alike, aims at causing the formation of either an active or a passive clot.

For the formation of a laminated clot it is essential that the blood shall continue to circulate through the sac, and that its flow shall not be sufficiently forcible to wash away the fibrin.

The more feeble the stream of blood, the less is it able to dilate the sac; and the more fibrin is deposited on the walls of the latter, the more capable will they be of resisting the blood-pressure. Now, the presence of an aneurysm on a vessel more or less impedes the flow of blood through it, and, consequently, the peripheral parts tend to become badly supplied. But in all parts of the body the obstruction to the circulation through any one vessel causes the blood to betake itself to other and less obstructed channels, and a "collateral circulation"

is established. This also occurs in the case of aneurysm, and, as the blood flows through other vessels, the circulation through the diseased artery becomes more feeble, and the tendency to the formation of a laminated clot is increased. The more feeble the patient becomes, the less is the blood-tension and the weaker the circulation, and so, in some cases at any rate, a natural cure takes place.

In addition, however, to this process of spontaneous cure—a tendency to which may be said to exist in all aneurysms—certain accidental circumstances may arise which favour the occlusion of the aneurysmal sac. The first of these accidents is the separation of a portion of the clot already formed in the sac, followed by its lodgment either in the mouth of the sac itself or else in the vessel on the distal side of the aneurysm. In the latter case, the artery being occluded and the circulation through it arrested, the collateral circulation will be opened up, less blood than formerly will flow through the aneurysm, and the latter may then be filled with laminated clot. It is evident that for such a curative process it is essential that the arteries which carry on the collateral circulation shall be given off on the cardiac side of the aneurysm, for if such is not the case, and the collateral branches come off between the mouth of the sac and the place where the vessel is plugged, just as much blood will pass through the diseased artery to reach the enlarged collaterals as previously passed along the main trunk itself.

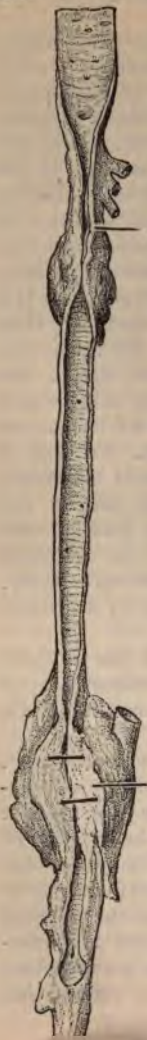
This method of natural cure by occlusion of the artery beyond the sac is imitated by the surgeon in the operation of distal ligature, an operation which only holds out hope of success when no important vessels are given off between the seat of ligature and the sac, as, *e.g.*, in the common carotid.

When the detached portion of clot lodges in the mouth of the sac itself, and so prevents either the ingress or egress of the blood, that blood which

remains in the aneurysm forms a passive clot and so fills up the sac. This mode of spontaneous cure is imitated in the treatment of aneurysms by the application of an Esmarch's bandage, the limb being emptied of blood above and below the aneurysm, while the sac of the latter remains filled. The bandage is left on a sufficient length of time to allow of a passive clot being formed before blood is again allowed to circulate. Other methods of spontaneous cure are described, but are certainly of rare occurrence. Thus, the sac is said occasionally to cause pressure on the artery above the seat of aneurysm, and, by thus diminishing the flow of blood, to cause the formation of a laminated clot. In other cases, again, the development of another aneurysm on the same vessel may cause the circulation in the latter to become so much retarded as to promote a cure. Of this I have myself seen one instance in the case of a woman, who died from an aneurysm of the first part of the right subclavian artery, and in whom a post-mortem examination showed another aneurysm on the third part of the same vessel completely filled with fibrin, and only communicating with the artery by a minute aperture.

Lastly, in some cases inflammation of the sac may cause the formation of clot. This is certainly a very rare event, and the occurrence of inflammation is a thing rather to be dreaded than desired.

In all cases of spontaneous cure, however promoted, there is another factor, namely, the tendency to contraction of the sac and of the surrounding tissues. The latter have been thrust aside by the growth of the aneurysm, and are, so to say, constantly endeavouring to overcome the dilating force and return to their natural positions. Any loss of power in the dilating force of the circulation in the aneurysm is consequently followed by a contraction of the surrounding parts and pressure on the sac itself—a contraction



which tends to continue until the former position of the displaced structures is restored.

EFFECTS OF LIGATURE AND OF PRESSURE ON ANEURYSMS.

Allusion has already been made to the mode of cure in the case of distal ligature, but a few words must be said on the results of the Hunterian operation. This operation consists in the application of a ligature to the diseased artery on the cardiac side of the sac. The result of such a proceeding is the occlusion of the artery at the seat of ligature, the diminution of the blood-stream through the aneurysm, and the gradual filling of the latter by laminated clot. The clotting in the sac extends to the artery, and thus the latter is occluded in two places—at the seat of ligature, and where it formerly communicated with the sac. Between these two points the vessel in most cases remains pervious, and this is always the case where any length of vessel intervenes, and where branches are given off between the ligature and the aneurysm. Where the ligature is applied close

FIG. 40.

The Femoral and Popliteal Vessels, five years after ligature of the superficial femoral for the cure of a popliteal aneurysm. The vessel has been occluded by the ligature at *a*, and again at the seat of aneurysm. The aneurysm itself is represented by a small mass of fibrous tissue, *b*. The artery between the ligature and the sac is patent.

above the sac, the clotting may extend along the intervening portion of artery. The application of pressure promotes the cure of an aneurysm by diminishing the blood-stream, just as does a ligature, but the vessel is not obliterated where the pressure is applied.

The changes that occur in the aneurysm after it has been filled by clot may be briefly described. The clot becomes in part organized and is in part removed. The aneurysm becomes very hard and fibrous, and shrinks rapidly. Some years after cure but little may remain of the original swelling beyond a small oval mass of fibrous tissue. This, together with other points in the cure of aneurysms, is well shown in the accompanying drawing of the arteries of the lower extremity of a man whose superficial femoral had been ligatured five years before death. The aneurysm is converted into a small fibrous lump which encloses within it the remains of the popliteal artery; the latter has been occluded for a length of about 3 inches. The superficial femoral has been occluded by the ligature, but between the seat of operation and the sac the vessel is pervious.

CIRSOID ANEURYSM.

Cirsoid aneurysm, or aneurysm by anastomosis, consists of a dilatation and elongation of one or more arteries. The dilatation of the vessels is in some cases tolerably equable, but, usually, each diseased artery presents numerous pouches or sacculi. The longer the disease lasts, the more extensive does it become, and vessels at first healthy are gradually involved. In many cases the veins and capillaries become greatly distended, and a fully developed aneurysm by anastomosis shows itself as an irregular pulsating tumour composed of large and tortuous vessels opening directly into one another. When a cirsoid aneurysm has existed for some time, the

walls of its constituent arteries become great thinned.

The patients in whom this form of arterial dise occurs are mostly young adults. It is usually fou upon the scalp and forehead; occasionally it co mences in a pre-existing nævus. The chief danger a cirsoid aneurysm is rupture and hæmorrhage.

CHAPTER XXVIII.

DISEASES OF VEINS.

VARIX.

A VEIN which becomes more dilated than is natural is said to be varicose.

The chief **causes** of varix are, mechanical obstruction to the venous circulation, and, weakness of the heart's action combined with general debility and loss of muscular tone. In addition to these, certain occupations and visceral diseases promote the development of varix in special localities.

The chief **situations** of varix are the leg and thigh, especially on the inner side, the anus and rectum, and the spermatic cord. In the lower extremity varicose veins are liable to be induced by any occupation which entails much standing, and so favours gravitation of the blood and increased pressure on the walls of the vessels which contain it. The superficial veins are more often diseased than the deep ones, for they are not supported by the muscles. The longer the column of blood, the greater will be the pressure on the veins, and for this reason the internal saphenous is more liable to varix than the external. The force of the arterial circulation is also diminished at the extremities of the body, and, especially when the heart is acting feebly, the arterial stream is not sufficiently vigorous to support and propel the venous blood. The constriction of the thigh by tight garters, and the pressure of the gravid

uterus on the iliac veins, are also well recognized causes of varix of the lower extremity.

Varix of the veins of the spermatic cord, or "varicocele," occurs much more frequently on the left side than on the right, and commonly originates about puberty. Its causes are supposed to be the length of the column of blood in a vein without valves, the tortuous course and frequent anastomoses of the veins near the testis, and the slight support afforded by the loose and yielding textures of the scrotum. The pressure of the rectum or sigmoid flexure is generally considered to account for the prevalence of varicocele on the left side, but the greater length of the left spermatic vein is a consideration of at least equal importance.

Varicose veins in the rectum, or hæmorrhoids, are specially caused by any obstruction to the circulation through the liver; by constipation, and consequent pressure on the rectal veins by scybalous masses; by the pressure of the gravid uterus, of uterine tumours, or of an enlarged prostate; and by sedentary occupations.

The anatomical changes in varicose veins are easily appreciated. On account of inability to support the blood-pressure, the vessel dilates, sometimes in its whole length, but more frequently at certain places where the pressure is greatest, *e.g.*, behind a valve or at the point of entrance of a branch vein. As the dilatation increases, the valves cease to act efficiently, and thus, when they are most needed to break and support the long blood-column, they gradually become useless, and, after a time, may almost completely atrophy. In some cases the vein-walls are thickened to resist the excessive pressure, the thickening being chiefly due to increase of fibrous tissue; in other cases, unable to withstand the dilating force, they become extremely thin and lacerable.

It is commonly supposed that, in the lower ex-

tremity, it is the superficial veins alone that become dilated; but this is not the case, for, in almost all patients in whom the superficial veins are varicose, the deeper ones are similarly affected, and the most prominent bulgings often mark the site of a communication between a deep and a superficial branch. But not only does a varicose vein increase in diameter; it also increases in length, and, in consequence, becomes curved and tortuous. This tortuous condition, in turn, causes still further obstruction to the blood-stream, and at the convexity of each curve, where the obstruction is greatest, pouches of large size are formed.

Effects of varicose veins.—In some instances no material effects result from varicosity of the veins, but in most cases of long standing the tissues which they drain suffer to a greater or less extent. One of the first effects of varix is congestion and swelling of the peripheral parts, with exudation of serum from the distended vessels and increased succulence of the soft tissues.

Sometimes matters go no farther than this, but very commonly the exudation increases and catarrhal inflammation of the skin, or eczema, ensues. After this, ulceration may follow, for the sodden and thinned epidermis is readily destroyed by the most trivial injury, and then the sensitive papillary layer of the skin is exposed. Such exposure results in inflammation, which rapidly progresses to the formation of an ulcer, and this, once formed, will tend to progress so long as the abnormal conditions of the circulation which produced it continue to act.

Another result of varicose veins is atrophy of the tissues in contact with them from the constant pressure of the dilated vessel. In this way the superjacent skin may become extremely thinned, so that in exceptional cases but slight injury is sufficient to rupture the dilated and exposed vein. Profuse hæmorrhage may thus be caused, and, although readily

arrested by pressure, a varicose ulcer may originate at the site of the rupture.

The thinness of the skin and the slowness of the blood-stream in varicose veins also predispose to phlebitis and thrombosis, subjects which are dealt with below. It is to attacks of inflammation that most of the more troublesome and painful symptoms of varicose veins are to be attributed rather than to their mere dilatation and tortuosity.

The discoloration of the skin in the neighbourhood of a varicose vein is the result of an escape of some of the red blood-cells and their subsequent disintegration. It is liable to occur in any tissues which are chronically inflamed.

THROMBOSIS AND PHLEBITIS.

Thrombosis is a coagulation of blood in a vessel, the resulting coagulum being called a **thrombus.**

Phlebitis is inflammation of a vein, and is frequently associated with thrombosis.

Coagulation indicates destruction of some at least of the normal constituents of the blood, and is the constant sequel of withdrawal of the blood from the vessels which naturally contain it, unless some special precautions are taken to prevent its occurrence.

Clotting of the blood is supposed to be the result of the destruction of leucocytes, and the freeing from them of a ferment which promotes the union of fibrinogen and fibrino-plastin, albuminoid bodies which normally occur in blood. So long as the blood is contained within vessels in a natural condition, there is little or no tendency to destruction of the leucocytes, and thus it may be said that contact with normal endothelium is sufficient to keep the blood in a fluid state.

The following are some of the chief **causes** of thrombosis :—

First, **retardation of the blood-stream.**—If

the flow of blood be retarded in any way, coagulation is likely to result. In wasting diseases, such as phthisis, the feeble circulation sometimes results in the formation of a thrombus in the vessels of the extremities, where the circulation is naturally most difficult. The blood clots first behind the valves, the blood-stream being too feeble to force them open. In other cases, the pressure of a splint, a bandage, or other mechanical appliance may produce clotting at the seat of pressure. The slowness of the blood-stream in varicose veins, already described, is another fertile source of thrombosis.

It is probable that retardation of the circulation causes thrombosis by itself producing an abnormal condition of the wall of the vessel. The latter thus ceases to exercise its normal control over the flowing blood, and on the death of the leucocytes coagulation ensues.

Secondly, **injuries.**—Any injury to a vein may cause thrombosis, but those which lay open the cavity of the vessel are more likely to do so than are mere contusions. Lacerated and jagged wounds are followed by more clotting than are clean incisions.

Thirdly, **contact with foreign bodies** or with tissues uncovered by endothelium.

In the case of the arteries, it has already been mentioned that thrombosis is likely to follow on destruction of the endothelium by atheroma. Atheroma is very rarely met with in the venous system, but the extension into a vein of a new growth, or the presence of foreign bodies, introduced from without, such as sutures, results in coagulation.

Fourthly, **certain constitutional conditions.**—In gout, typhoid fever, pregnancy, and in many of the various forms of blood-poisoning there is a tendency to the formation of thrombi. Whether this is the result of some alteration in the blood itself, or of some change in the vessel-wall, is not certain.

Fifthly, **extension of inflammation** from surrounding parts, and the consequent causation of phlebitis.

PLASTIC PHLEBITIS.

All cases of thrombosis were formerly supposed to originate in phlebitis, but, whilst it is now quite certain that this is not true, there has been too great a tendency to believe that plastic phlebitis does not exist. It would certainly be more than strange if one of the tissues of the body was found to be unassailable by a process which spares none other, and, as a matter of fact, we find that veins, like other structures, are liable to inflame.

As far as can be ascertained at present, however, idiopathic phlebitis does not exist, and, unless it is caused by such constitutional conditions as gout, typhoid fever, &c., already mentioned as causes of thrombosis, it always owns a local origin.

The following causes may result in inflammation of a vein :—

First, **injuries.**—If a vein be cut across, as in an amputation, it, like all other injured structures, becomes the seat of a local inflammatory process which results in the exudation of lymph, both into the walls and into the cavity of the vein. This lymph usually undergoes organization into fibrous tissue in exactly the same way as in arteries which have been injured. If the injury has been a clean cut not completely dividing the vein, the resulting scar will be imperceptible. Contusions and lacerated wounds are also liable to cause local phlebitis, and continuous pressure may produce a like result.

Secondly, **extension of inflammation** from surrounding parts.

In all cases of inflammation, the veins share in the changes which occur in the parts around them. Exudation of cells, vascularization of the inflammatory *products*, softening of the vein-wall, and finally

destruction by suppuration may all ensue. If the inflammatory exudation takes place beneath tense structures, such as fasciæ, the pressure of the exuded material is liable to give rise to a widespread thrombosis, in addition to the clotting which results from the inflamed state of the vein-walls.

Thirdly, **presence of a thrombus.**—A thrombus in a vein causes a certain amount of irritation, and inflammation of the vein-wall ensues. The termination of this phlebitis will depend upon the character of the clot; suppuration occurs only when the latter is in a septic condition.

The changes that occur in the vein as the result of phlebitis are such as are common to all inflammations, and need no special description. The effect of the phlebitis on the circulating blood is the formation of a thrombus, and the consequent blocking of the affected vein. This may certainly occur independently of exudation of lymph into the cavity of the vessel, and results from the injury done to the endothelial lining by the inflammatory process.

It will thus be seen that whilst, on the one hand, thrombosis may cause phlebitis, on the other, phlebitis results in thrombosis. Further, the same causes which produce thrombosis may also cause phlebitis, and in many cases it is quite impossible to say whether the thrombosis is primary, or whether it is secondary to an antecedent phlebitis.

When a thrombus has been formed in a vessel, it may extend either with or against the blood-stream, and frequently it grows in both directions. The blood on each side of the thrombus is not in a stagnant condition, but, on the contrary, is kept in a state of constant and regular agitation. Consequently, the thrombus increases not only by a gradual extension of coagulation through a column of stagnant blood, but by the separation of fibrin which results from the constant movements of the fluid.

If the clot extend towards the heart, its formation

is usually arrested when it reaches the orifice by which the occluded vein opens into a larger trunk, a termination which is promoted by the greater vigour of the circulation in such a vessel. Such an arrest is not, however, of constant occurrence, for it occasionally happens that clot or fibrin is deposited upon the thrombus where it protrudes into the main trunk, and by a continuance of this process the latter may itself be occluded.

When the clotting progresses against the blood-stream, it does not usually extend beyond the first patent collateral branch. If the original thrombosis has commenced in a main vein, such as the femoral, then, on account of the great interference with, and the retardation of, the blood-stream, clotting is liable to be very extensive.

Changes in the thrombus.—The first and most constant change is **contraction.** This contraction is always very noticeable in a blood-clot formed outside the body, and, for long after the formation of the coagulum, serum continues to be squeezed out. Exactly similar changes occur in the thrombus formed in a vein, and, in consequence, the wall of the vessel is puckered at the places where the plugged branch veins enter it, although when examined post-mortem the vein as a whole is much more distended and prominent than is a healthy vessel. All thrombi are more or less adherent to the vein-wall. In most cases the adhesion is simply by coagulated fibrin, but is occasionally, in old clots, by fibrous tissue.

After it has contracted, the thrombus becomes gradually decolorized, the red blood-cells disintegrating, and their colouring matter being diffused and removed in the manner already described in the chapter on "Contusions." The older a clot, the whiter it is.

In very many cases the clot is finally **absorbed** in great part, if not entirely. It is most probable that this absorption is to a large extent the result of simple degenerative changes which occur in its more central

parts in consequence of insufficient nutrition; but there can be little doubt that much of the absorption is due to the action of leucocytes which are exuded into the clot from the wall of the vein in which it lies. It is a well-ascertained fact that the removal of clots outside the vessels is due to the action of white blood-cells, and, as the number of leucocytes in a thrombus constantly increases from the time of its first formation, it is highly probable that here also they are employed in a similar work.

When absorption does not take place, **organization** may ensue. The process is the same as that already described as occurring in the internal clot in arteries after injuries, and is the result of an exudation of leucocytes into the clot, and their development into fibrous tissue. This fibrous tissue afterwards contracts, just as does a scar, and may either draw the vein-wall with it, or may shrink to one side of the vessel and so allow of the re-establishment of the circulation. Much more rarely the blood bores a hole through the organized clot, and thus, as it is termed, "tunnels" the thrombus.

Lastly, thrombi which are of long standing may undergo calcareous degeneration and form "phleboliths." These small concretions are very common in the veins of the prostatic plexus in old subjects.

Results of thrombosis.—The result of the arrest of the circulation in any vein will depend on the freedom with which the blood is able to return by other channels. Where the occluded trunk is small and superficial, the tissues which it drains may present no change. If, on the contrary, the vein be the main one of the limb, *e.g.*, the femoral, then there is, at first, a bluish discoloration with swelling, followed, after a time, by a dead-white colour and a solid sort of œdema, with alteration in the shape of the leg and thigh. When the vein is permanently blocked, this œdematous condition may persist for years, and is generally

attended by much interference with the usefulness of the part.

Rarely, portions of clot become detached, and are carried by the circulation to the right side of the heart, and thence to the lungs. The effects of this embolism of the branches of the pulmonary artery depend almost entirely on the size of the embolus, and the consequent interference with the pulmonary circulation.

SUPPURATIVE PHLEBITIS.

Suppurative phlebitis is always the result of septic changes in the tissues around the vein, and is usually the result of a wound. There is no such thing as idiopathic or primary inflammation of a vein, with exudation of pus into its cavity.

Suppurative phlebitis, indeed, is usually accompanied by diffuse cellulitis, an inflammation which readily extends along the cellular tissue which surrounds the venous trunks. There is thus a so-called "periphlebitis," and the inflammatory changes secondarily extend to and implicate the vein-wall itself. In consequence of the alteration thus produced in the lining membrane, the blood clots, and the vein is plugged. The inflammation progresses, and the vein-wall is involved in the suppuration. Finally, in parts, the coats of the vein are destroyed, and pus now mingles with the clot already formed. Hæmorrhage does not occur, and the pus does not mingle with the blood, for the reason that clotting always precedes the extension of suppuration into the vein. In suppurative phlebitis, the clot never becomes absorbed or organized, but is always destroyed with the vein in which it lies. Circulation, therefore, is never re-established in the vein itself.

There is another way in which suppurative phlebitis may originate. In cases of pyæmia, the clots which are formed in the veins become themselves impregnated with septic material absorbed from the wound.

These clots excite suppurative inflammation in the vessels which contain them, and the clots themselves become disintegrated and mingled with the products of inflammation. If portions of these broken-down and septic clots are carried into the circulation, not only will they cause embolism of the pulmonary vessels, but wherever they lodge they will infect the tissues in which they lie, and will excite in them a septic inflammation similar to that which was in progress in the part from which they were originally derived. (See Pyæmia.)

CHAPTER XXIX.

EMBOLISM.

Embolism is the term applied to the plugging of a vessel by a foreign body—usually a blood-clot—which has been carried from a distance by the blood-stream. The foreign body is called an embolus.

An embolus may be formed in either the arterial or venous system; on the left or right side of the heart. Most commonly it is formed in the left side of the heart, and consists of fibrin or blood-clot from diseased aortic or mitral valves. In some cases these emboli contain calcareous material. An embolus originating in the heart will, when swept into the blood-stream, be carried into the systemic circulation, and will be arrested when it comes to a vessel too small to allow its transit. Very commonly the arrest occurs above a bifurcation.

In other cases the embolus originates in a vein, and then consists of clotted blood. If a portion of clot in a thrombosed vein be detached, it will be carried to the right side of the heart, and thence into the pulmonary circulation, where it will plug some branch of the pulmonary artery.

The immediate result of the lodgment of an embolus is the partial or complete arrest of the blood-stream. Very shortly, the blood clots at the seat of embolism, and a thrombus is thus formed around the embolus. The presence of the embolus excites inflammatory changes in the vessel-wall, and from the

vasa vasorum of the latter new vessels are developed, which penetrate the embolus and its surrounding clot. Inflammatory exudation now occurs, and the clot, becoming organized, adheres to the vessel-wall. In this way the plugged artery is permanently occluded.

Such is the usual result of embolism, but, in rare cases, the embolus, being composed of soft clot, may be disintegrated, and the channel of the vessel may be re-opened. In other, and still more rare, instances, an aneurysm may form at the seat of embolism, as described in the chapter on Aneurysm.

In addition to the local effects of embolism, the parts to which the plugged vessel is distributed suffer from deficient supply of blood. The moment that the artery is occluded, the patient usually suffers severe pain at the place where the embolus lodges, while in the peripheral parts he experiences sensations of numbness, with superficial burning pain and loss of power in the muscles. Unless the collateral circulation enlarges, the most distal parts will gradually pass into a condition of dry gangrene, and, in some cases, such a result is hastened by the detachment of small portions of the embolus or its surrounding thrombus, and consequent embolism of other and more distal vessels. (See Gangrene.) In many cases of embolic gangrene, complicated by heart disease, the patient does not long survive the death of the limb.

The effects of embolism of a branch of the pulmonary artery depend to a great extent on the size of the occluded vessel. If very large, death may ensue almost instantaneously; if not, recovery may follow after temporary consolidation of the lung around the plugged vessel. The subject of "septic embolism" has already been dealt with in the chapter on Pyæmia.

Instead of blood-clot and fibrin, an embolus may be composed of portions of a tumour which has grown into the surrounding vessels without causing their obliteration, *of micro-organisms*, of fat, of parasites,

&c. Such cases are necessarily of considerable and, with the exception of fat embolism, of nc practical importance. **Fat embolism** is of son rest, for it seems to explain cases of death aft simple and compound fractures which would wise be obscure. It results from the destruction fat-cells in the fractured bone and the passage granules—often aided by the tension produced flammatory exudation—into the lymphatics and From these vessels the fat is carried to the lun causes obliteration of the pulmonary capillaries

CHAPTER XXX.

DISEASES OF THE LYMPHATIC SYSTEM.

LYMPHANGITIS.

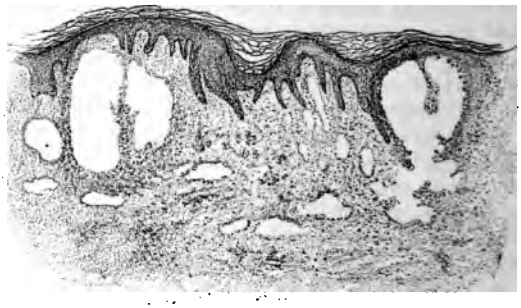
Lymphangitis, or inflammation of the lymphatic vessels, is commonly the result of the transmission by them of irritating material from a wounded surface. It is especially prone to follow poisoned wounds of all kinds, more particularly those in which the poison is an animal one, and is thus frequently seen in cases of post-mortem or dissection wounds, as well as in the injuries sustained by butchers from implements used in their work. In many cases the injury is extremely slight, such as a scratch or a prick, and the retention of pus even in minute quantities seems to greatly favour the development of the disease. Commencing in the radicles of the lymphatic system, the inflammatory process extends along their cellular-tissue sheath as well as in the vessel-wall itself; when the trunk is a superficial one, the skin commonly shows a red line in the course of the affected lymphatic. As a result of the inflammation, the vessel-wall becomes thickened and its contents turbid or coagulated. Sometimes suppuration ensues, and very often lymphadenitis complicates the course of the disease.

LYMPHANGIECTASIS AND LYMPHORRHŒA.

Lymphangiectasis, or dilatation of lymphatic vessels, results *from anything* which obstructs the flow of

lymph to such an extent that the collateral as well as the main channels are closed. This condition sometimes results from a chronic lymphangitis, but more often from the pressure of some new growth. In not a few instances no cause can be assigned. The common situations for varicose lymphatics are the inguinal regions and the inner side of the thigh. The appearance of the skin in such cases has been likened to the rind of an orange, and when numerous lymphatics are much dilated they present just the same tortuous outline, with pouches at the curvatures, as do varicose veins. They are, however, quite colourless, and only covered by the surface epithelium. Occasionally, in connection with this disease there is a rupture of the dilated vessels and a discharge of lymph —a condition known by the name of **lymphorrhœa.**

FIG. 41.



Lymphangioma from the Skin of the Buttock. The dilated lymph spaces causing protrusion of the surface, epithelium are well seen.

Lymphangioma is merely an exaggeration of lymphangiectasis, the dilated lymphatics forming definite swellings or tumours. These growths are sometimes congenital, and I have seen one on the buttock of a boy which looked like a diffuse papilloma, with very translucent papillæ. Microscopically, the

growth is seen to be composed of dilated lymphatics. In cases of macroglossia also, much of the enlargement is found to be due to dilated lymph-channels.

ELEPHANTIASIS ARABUM.

The term elephantiasis is applied to all forms of chronic hypertrophy of the skin and subcutaneous tissue which result in the production of much deformity. The term spurious elephantiasis has been lately applied to those cases in which the disease is the result of inflammation of no specific or definite form. Good examples may be seen in the enlargements of the legs of patients with chronic ulcers, or of the scrotum in cases of long-standing urethral strictures with fistulæ. The enlargement is due to an over-growth of the connective-tissue elements of the parts. This increase is due both to the vascularity of the chronically inflamed tissue and the attendant exudation, and also to the subsequent interference by pressure with the flow of lymph in the lymphatics.

The term **true elephantiasis**, or **elephantiasis arabum**, is applied to a special form of the disease which is endemic in certain countries—notably certain parts of Asia, Arabia, and Barbadoes—and which develops independently of previous local conditions. The natives of the countries infested by the disease are more liable to attack than are Europeans, and it is supposed by some writers that the want of clothing on the legs and feet renders these parts more susceptible. The onset of the disease is marked by fever, and the skin of the affected part—generally the leg or scrotum—becomes red and inflamed, with small vesicles on the surface. These attacks of cutaneous inflammation frequently recur, and each one leaves in its train a permanent distension of some of the lymphatics. The subcutaneous tissue is at first soft and œdematous, and pits on pressure; after a time, it becomes *hard and brawny*, and the skin is either

covered with vesicles and dilated lymphatics, or, in the later stages is eczematous, roughened, tubercular, and horny. The amount of newly formed fibrous tissue is frequently enormous, the scrotum weighing as much as one hundred pounds or more, and the thigh measuring one or two feet in diameter.

The cause of true elephantiasis has long been the subject of much speculation, and it has been attributed to exposure to excessive heat, to the absorption of poison by the skin, to an inherited predisposition, &c. It is very generally believed at present that the disease is the result of the passage of a nematode worm (the filaria sanguinis hominis) into the lymphatic tissues. The adult female worm is about $3\frac{1}{2}$ inches in length, and as thin as a very fine hair, having a breadth of about $\frac{1}{100}$ of an inch; the adult male has not yet been obtained entire, so its length is uncertain, but in breadth it is about $\frac{1}{100}$ of an inch.

The worm breeds freely in the human body, and appears to choose for its habitat some of the lymphatic tissues, just as the trichina selects muscle. The embryos, which are about $\frac{1}{70}$ of an inch in length, and $\frac{1}{3500}$ in width, are endowed with free mobility from their birth, exhibiting lashing, eel-like movements when placed under a microscope. They readily make their way along the lymphatic vessels, and, reaching the thoracic duct, enter the blood-stream. In the blood of an affected person they are usually entirely absent during the day, beginning to appear about evening, and being present in enormous numbers during the night. This periodicity depends on the wakefulness or otherwise of the patient, for, if sleep be taken during the day instead of at night, the filariæ also change their habits. Where they disappear to during the waking hours is not known, and it has been suggested that none of them live more than a night, and that each evening a fresh brood is produced. These embryo filariæ do not undergo further development whilst

in the human body, but it appears from the investigations of recent observers—especially Manson—that the mosquito is their next host. They are taken up by the mosquito when the latter draws blood at night, and in it they further develop, cause the death of their host, and then escape into the water near which these insects usually live. From the water they may gain access to man either by the alimentary tract or through the skin. There is yet some doubt in which of these ways, but the former appears much the more probable.

The presence of filariæ is supposed to produce elephantiasis by keeping up a chronic irritation and inflammation of the lymphatics in which they breed, but it is also suggested that the lymphatic vessels themselves are occasionally mechanically blocked by prematurely discharged, immature ova which have a much greater transverse diameter than the embryo filariæ. It may be mentioned that other diseases are also ascribed to the presence of the filaria sanguinis hominis, especially some forms of endemic hæmaturia, chyluria, and hydrocele containing chylous fluid.

LYMPHADENITIS.

Lymphadenitis, or inflammation of a lymphatic gland, is generally the sequel of an injury to, or inflammation of, some peripheral part in which the lymphatic vessels passing to the inflamed gland arise, and is often a complication of lymphangitis. In some cases direct injury appears to act as the exciting cause; in others, excessive or long-continued exercise may start the affection. Inflammation of lymphatic glands is also met with in various forms of specific disease, *e.g.*, gonorrhœa, erysipelas, &c., but at present only the simple non-specific inflammations will be considered.

The affected gland presents all the ordinary appearances common to inflammations in general; it

becomes vascular, soft, and swollen, and the loose connective-tissue in which it lies shares in the pathological changes. On section, it is found to contain a good deal of fluid, and microscopical examination shows that it is infiltrated with leucocytes, which are especially numerous in the cortex. Lymphadenitis may terminate in different ways. In favourable cases resolution occurs, the vascularity subsides, and the exuded leucocytes return to their lymphatic channels. Very commonly suppuration results, the leucocytes increase in number, many of them die, and thus small collections of pus form in different parts of the gland and in the surrounding cellular tissue. These collections run together, and an abscess forms and comes to the surface. In severe cases the inflamed gland sloughs, and the abscess which necessarily occurs in such cases exposes, when it bursts, the necrosed gland lying in its floor. Where the cause of the original inflammation is itself persistent, the inflammation becomes chronic, the leucocytes, as in all chronic inflammations, tend to develop, and the affected gland and the neighbouring tissues are enlarged and indurated by the growth in them of connective tissue. If the patient be strumous, the inflammatory products will caseate in the manner already described in the chapter on Struma.

TUMOURS OF LYMPHATIC GLANDS.

Lymphoma.—A lymphoma is a tumour composed of lymphatic glandular tissue. Its most common situation is the neck, and it may affect one or more glands. Lymphomata vary in size, and, although it is seldom that any single gland attains a greater size than that of a hen's egg, several affected glands may together form a mass of considerable bulk. These growths are encapsuled, do not infiltrate the neighbouring tissues, and, although often rather adherent, do not show signs of inflammatory thickening. The ·rs are not malignant, and are painless. On

section, except for their unusual size, they present the appearance of a normal lymphatic gland. Microscopically, they do not differ from lymphoid tissue, and it is difficult to say whether they should be classed amongst the simple hypertrophies or the new growths.

Lymphadenoma.—Lymphadenoma is a disease characterized by overgrowth of lymphatic glandular tissue in many parts of the body. The growth is most common in the lymphatic glands themselves, but is found also in the medulla of bones, the intestinal canal, the spleen, and the connective-tissues. As regards the lymphatic glands, the new growth is in some cases soft and almost brain-like (**soft lymphadenoma**); in others, hard, elastic, and tough (**hard lymphadenoma**). In the first variety, contiguous diseased glands not infrequently cohere, and also become closely adherent to the surrounding tissues. The growth is in many cases very rapid, and neighbouring parts may be either compressed or infiltrated. On section, the diseased glands present a greyish or greyish-white tint, mottled in places with red. Microscopically examined, the growth is seen to be composed of round cells, similar to those of a lymphatic gland, and lying in a delicate matrix of connective tissue arranged in the form of a network. The structure differs from normal gland chiefly in the great excess of cells and the small amount of connective tissue. These growths are often called **lympho-sarcomata.** Their presence is frequently accompanied by great debility, anæmia, and exhaustion, with emaciation, diarrhœa, and vomiting. They may cause death in this manner or by pressure on important viscera. Their development is often associated with secondary growths in the viscera and in the bones.

The hard lymphadenomata are not so malignant as the soft variety, being slower in their growth, more encapsuled, and less widely distributed. The

disease tends to extend along the several glands, forming a lymphatic chain, rather than to affect many different groups or to occur in the viscera. In structure the hard lymphadenomata differ from the soft variety in the greater abundance of their fibrous stroma—a condition which accounts for their greater firmness. Between the hard and soft lymphadenomata transitional forms may be found.

In some cases of lymphadenoma, and especially in the soft variety, **leucocythæmia** is present. In this disease there is a large increase in the number of the white corpuscles of the blood, and usually a great enlargement of the spleen. A fatal termination is very common.

Sarcoma.—Sarcoma of a lymphatic gland occurring as a primary growth, not of the variety already described as lympho-sarcoma, is of rare occurrence. Such tumours are, however, occasionally met with, and I have seen two such cases affecting the axillary glands. In one the growth was composed of large, in the other of small, round cells. Other varieties have been described.

The frequency with which the lymphatic glands are secondarily affected by malignant tumours is well known, and is mentioned in connection with the new growths of different organs.

CHAPTER XXXI.

DISEASES OF THE THYROID GLAND.

Inflammation of the thyroid apart from other diseased conditions is an event of some rarity, although it is by no means uncommon for a goîtrous gland to become inflamed. The changes that occur are such as are seen in similar conditions of other soft tissues, and the inflammation occasionally terminates in the formation of pus.

Atrophy of the thyroid is a frequent accompaniment of myxœdema, but is otherwise of no importance.

GOÎTRE, OR BRONCHOCELE.

The term goître is applied to any enlargement of the thyroid gland which is not caused by inflammation or malignant growth; its causes have been much discussed, and are not yet satisfactorily settled. In some cases the disease is hereditary, and commonly commences in early life; in a very large percentage of instances it occurs only in certain definite localities, where it is endemic.

The disease is considered by some writers to be caused by any occupation or habit which favours congestion of the veins of the neck, such as the playing of wind instruments. For many years goître has been attributed to drinking water derived from melted snow or ice; but there does not appear to be any truth in this theory. It is also supposed—and with more probability—to be due to the presence of large quantities of lime salts in drinking-water.

Structurally, goîtres may be divided into four classes, though it must be remembered that between all of these there are connecting links, and that more than one of the morbid conditions may be found in the same growth.

First, **simple hypertrophy.**—In this form there is an overgrowth of the glandular tissue, and in most instances the enlargement is symmetrical, both lobes as well as the isthmus being hypertrophied in proportion to their original size. In other cases localised hypertrophies occur, and definite glandular tumours —true adenomata—may develop in the substance of the lateral lobes or in the isthmus. Whether the growth be universal or local, the new tissue does not differ from that of a healthy gland, being composed of closed vesicles lined by epithelium containing a clear sticky fluid, embedded in a stroma of loose connective-tissue.

Second, **cystic goître.**—In cystic goître there is a development of cysts of unusual size. These cysts commonly occur in glands in which there is also some true hypertrophy, but may develop in otherwise healthy thyroids. They are formed by a mucoid or colloid degeneration of the walls of separate vesicles, which are thus thrown into one another, and form cavities of various dimensions. Such cysts are sometimes single, but more often multiple. They contain either clear serous fluid, viscid colloid material, or a dark bloody liquid, with a grumous or coffee-ground like deposit.

Third, **fibrous goître.**—In fibrous goîtres there is an excess of the fibrous stroma as compared with the glandular tissue. The fibrous growth is common in old goîtres, and generally occurs in a gland which has previously been the seat of simple hypertrophy. In other goîtres of long standing calcareous degeneration is frequently met with, and in some cases the whole thyroid is converted into a calcareous mass.

Fourth, **pulsating goître.**—This is a form of bronchocele in which there is an excessive development or dilatation of the vessels. It more often complicates cases of simple hypertrophy than the other varieties of goître. Pulsating bronchocele is sometimes associated with protrusion of the eyeballs.

The effects of a goître depend both on its size and on the rapidity of its growth. The veins leading from the enlarged gland become distended, and in many cases those of the head and neck are subsequently dilated. Pulsation in the carotids is occasionally increased, but in some instances the growth causes pressure on these vessels, and, by interfering with the blood-current, induces cerebral anæmia, with spasm or convulsions. Spasm of the glottis or paralysis of the laryngeal muscles may also result from irritation of the recurrent laryngeal nerve. The most important result of enlargement of the thyroid is, however, interference with the passage of air through the trachea, which is usually compressed on either side by the two lateral lobes, but may in rare instances be narrowed by the pressure exercised by the enlarged isthmus in front. In other cases the growth extends between the sternum and trachea, and squeezes the latter against the spine. Even in cases where no urgent dyspnœa exists, it is common for a bronchocele to produce some shortness of breath on exertion. The large majority of goîtres do not cause death, and a fatal termination is much more common in the rapidly growing tumours than in those of slower growth, even although the latter attain a greater size. The name acute bronchocele has been given to these quickly developing goîtres, and the dyspnœa which they cause is explained by the fact that the fasciæ and muscles of the neck have not time to stretch and provide room for their development; hence, all hollow and compressible structures necessa-

rily suffer. In cases of cystic bronchocele, the cysts sometimes rapidly increase in size on account of the effusion of blood into their cavities.

MALIGNANT DISEASE.

Sarcoma is rarely seen in the thyroid gland, but carcinoma is not uncommon. The latter growth usually affects thyroids which have previously been the seat of goîtrous enlargement, and is commonly diffused throughout the entire gland. The tumours are usually of the encephaloid variety, but occasionally they are scirrhous in type; sometimes they very closely simulate the normal glandular structure, and can only be distinguished from cases of simple hypertrophy by the infiltration of the neighbouring tissues and by their malignant clinical course. All growths of this class are liable to cause glandular enlargement, and to produce secondary growths in the viscera and bones. They usually run a rapid course, and terminate fatally, either by local complications or visceral disease.

CHAPTER XXXII.

INJURIES AND DISEASES OF MUSCLES, TENDONS, AND BURSÆ.

Rupture of muscle.—Considering the constant strains to which they are subjected, muscles are but seldom torn, and, when they are ruptured, it is rather by a sudden and unexpected strain than by the employment of great muscular force. The ends of a ruptured muscle immediately retract, and remain separated by an interval which varies in extent in different cases. A certain amount of blood is always extravasated, and may form a considerable hæmatoma.

Union of the torn muscle is accomplished by a process of plastic inflammation, with exudation of lymph, and its subsequent organization into fibrous tissue.

Wounds of muscle are followed by separation of the cut fibres, and in such injuries, as in rupture, repair is effected by fibrous tissue. Muscle may be said never to be reproduced, for, although attempts at reproduction of muscle-fibres have been described, the amount of new muscle thus formed is quite microscopic.

Inflammation of muscle.—Muscles are but little prone to inflammation, and, when affected by so-called **myositis**, the latter is the result either of injury, of inflammation spreading from surrounding parts, or of such constitutional conditions as pyæmia and typhoid fever. The course of the inflammatory process in muscle does not differ from that in other tissues, and requires no special description.

Atrophy and degeneration of muscle.—The most common cause of muscular atrophy is disuse, and in cases where a limb has remained unused for years, as in chronic disease of a joint, the whole of the muscles may be so atrophied that no contractile tissue remains, the muscle-sheath being filled with a mass of fatty and fibrous tissue. The wasting of muscle which follows nerve section has already been mentioned, and the various forms of atrophy and degeneration which are dependent upon disease of the central nervous system—*e.g.*, infantile paralysis, progressive muscular atrophy, &c.—do not come within the scope of the present work.

Ossification of muscle.—The formation of bony plates in muscle is a condition far more often met with in men than in women. Occurring in single muscles it is by no means very rare, and is found most frequently in the deltoid and the adductors. The bony deposit occurs at the osseous insertion of the muscle, and appears to be produced either by constant strain or by frequent though slight contusions. The development of bone in the adductor muscles is most common in men who ride, and results in the production of the so-called "riders' bone."

In other, and fortunately rare, instances, the tendency to the formation of bone is found in many muscles, and cases are described in which the back and neck have thus become encased in a broad osseous cuirass, resulting in the complete immobility of the affected parts. The cause of such a condition is quite unknown. It has been named "myositis ossificans," and appears to be either of congenital origin or else to commence very soon after birth.

Tumours of muscle.—Primary tumours of muscle are rarely met with. The few cases that are recorded are almost all instances of sarcomatous growths. In four cases with which I am acquainted the tumours were of rapid growth and ran a malignant course. The cells of which they were composed were n[illegible]al.

Syphilitic affections of muscles.—Gummata occur with tolerable frequency in the muscles, and appear to have a decided preference for those of the neck, and especially for the sterno-mastoid. They often attain a considerable size, and may be as large as a hen's egg. They do not differ structurally from gummata elsewhere.

INJURIES AND DISEASES OF TENDONS AND THEIR SHEATHS.

Wounds and ruptures.—Tendons are more liable to rupture than are muscles, notwithstanding their tougher and denser structure. The injury is at once followed by retraction of that portion to which the muscle is attached, whilst the other end does not alter its position except as the result of the movements of the part into which it is inserted. Repair is effected by a process of plastic inflammation. The exuded inflammatory products collect chiefly in the tendon-sheath, and in it undergo development, first into fibrous tissue, and subsequently into tendon. Repair is at once both rapid and complete, the newly formed tendon being capable of supporting considerable strain within two or three weeks, and finally becoming indistinguishable, even by microscopic examination, from the neighbouring tendinous structures.

In wounds of tendons unaccompanied by the formation of pus—*e.g.*, in tenotomy for talipes—the process of repair is exactly the same as that above described; but in open wounds accompanied by much suppuration the tendons and their sheaths are liable to become matted to one another and to the surrounding parts in such a way that their future utility is either destroyed or greatly impaired. The prospect of union in such cases is greatly enhanced by careful suturing at the time of the accident, or even at a later date if repair has failed.

There are but few **diseases** to which tendons are

liable, for they may be said to be never affected by inflammation or new growth except when secondarily implicated by extension from the surrounding parts. Gummata are rarely met with, but gouty deposits of urate of soda are not uncommon in the tendons of the foot and ankle. Fibrous tumours occasionally grow in connection with the tendon-sheaths of the fingers.

Teno-synovitis.—Teno-synovitis, or inflammation of the synovial lining of a tendon-sheath, is usually a sub-acute affection, and is most often seen in the extensor tendons of the wrist. The exciting cause is almost invariably excessive use of the muscles, and the constant friction of the tendons within their sheaths gives rise to roughening by the deposit of lymph, and a consequent creaking or crepitating sensation when the hand is placed over the affected part. The inflammation is usually transitory, and readily subsides with rest, but it is liable to recur when the muscles are again called upon for any unusual exertion.

Ganglion.—Ganglia are of two kinds—simple and compound. Each variety is most frequently seen in the sheaths of the tendons on either the palmar or dorsal surface of the wrist, or on the dorsal surface of the ankle. Ganglia are most common in those who are in the habit of using to excess the muscles of the wrist.

A simple ganglion is usually described as being a hernial protrusion of a portion of synovial membrane through an aperture in the sheath of the tendon, and it is supposed that the communication with the tendon-sheath being subsequently cut off, a small pouch of synovial membrane is thus left outside it. It is much more probable that Paget's description is correct, which attributes the formation of a simple ganglion to a cystic degeneration of one of the synovial fringes normally present inside the [illegible]n-sheath. If this be true, it follows that the

fluid contained in the ganglion is never at any time in communication with the cavity of the synovial lining, but is shut off in a cyst, which, from the first, is a closed cavity. However formed, a simple ganglion presents itself as a rounded, tense cyst, generally about the size of a hazel-nut, but occasionally larger, and containing a perfectly clear material of the consistency and appearance of glycerine jelly. The presence of a simple ganglion is liable to cause stiffness and pain in the affected tendon.

Compound ganglia are most common on the sheaths of the flexor and extensor tendons of the wrist. They are formed by a distension of the synovial sheaths with fluid, and may attain considerable size. In addition to sticky and inspissated synovia, they often contain numerous small, oval or rounded, smooth masses of fibrin, of the size and appearance of melon-seeds. A compound ganglion always materially interferes with the movements of the tendons, and in time may completely cripple the hand.

Dupuytren's contraction is the name applied to a contraction of the fingers which results in some cases from the use of some tool or instrument which causes pressure on, and irritation of, the tissues in the palm of the hand. In other cases it occurs in connection with the rheumatic or gouty diathesis. The little finger is usually first affected, and after it the ring. Dissection shows that this deformity is not caused by contraction of tendons, but by thickening of bands of fascia which are inserted into the base of the phalanges, and in time become adherent to, and cause puckering of, the skin. In cases of long standing, the metacarpo-phalangeal and the first inter-phalangeal joints become more or less fixed, their articulating surfaces being in bad cases dislocated.

DISEASES OF BURSÆ.

The commonest disease of a bursa is simple distension with *serous* fluid. This distension is liable

to follow chronic irritation of any kind, and, when the cause has been removed, will usually subside spontaneously.

If the irritation be kept up, chronic inflammation, with thickening of the bursal walls by fibrous tissue, will ensue, and is occasionally combined with the formation of "melon-seed bodies," such as those already mentioned as occurring in compound ganglia. In some cases the walls of a bursa become so greatly thickened that the cavity is almost completely obliterated, and the bursa is practically transformed into a fibrous tumour.

Acute inflammation and suppuration of bursæ are also of common occurrence, and, if the bursal wall be not already thickened by old inflammation, the pus is liable to burst its way out, and to become diffused into the surrounding tissues.

Tumours of bursæ are very rare, but syphilitic gummata are not uncommon.

The bursæ which are most commonly the seat of all forms of disease are those over the ligamentum patellæ and the olecranon. Simple distension is also common in those situated over the tuber-ischii and the great trochanter, as well as in the bursa which lies in the popliteal space between the inner head of the gastrocnemius and the semi-membranosus.

CHAPTER XXXIII.

DISEASES OF BONE.

ATROPHY.

Atrophy of bone, like the same process in other parts of the body, is the result of deficient use or of continuous pressure. The extreme wasting of the bones of stumps or of limbs with diseased joints affords an excellent example of the first cause, whilst the hollowing out and absorption of the sternum and vertebræ from the pressure of an aortic aneurysm well illustrate the second.

Two kinds of atrophy are described in long bones, but they frequently co-exist. **Eccentric** atrophy is a hollowing out of the bone from within, so that, whilst it maintains its natural shape and size when viewed from without, it is found, on section, to be reduced to a mere shell. Atrophy of this kind is often seen in aged people. In **concentric** atrophy the whole circumference and diameter of the bone are diminished, and its shaft is much more slender than is that of the opposite side. Such a bone, on section, is often found to be the seat of eccentric atrophy as well.

HYPERTROPHY.

True hypertrophy is not common. It chiefly results from increased blood-supply and from excessive use. Good examples of the former are occasionally supplied by cases of chronic inflammation in the neighbourhood of an epiphysis in a young subject,

for, on account of the increased vascularity of the epiphysial bone, growth may be stimulated to such an extent that, in the course of years, a limb may outgrow its fellow by several inches. Better examples of pure hypertrophy are afforded by cases where a bone is called upon to bear undue weight: *e.g.*, in congenital absence of the tibia, the fibula may be greatly enlarged; and in hydrocephalus the increased size of the brain is met by a corresponding increase in the cranium.

INFLAMMATION.

In considering the subject of inflammation of bone, it must be remembered that the osseous structure is practically ossified connective tissue, and that almost all that has been written in the chapter on "Inflammation" is strictly applicable to bone.

In osteitis, then, there are, first, hyperæmia and stasis, followed in quick succession by formation of new blood-vessels and exudation, with softening of the inflamed tissue, a change which plays a most important part in the course of inflammation of bone.

The blood-vessels of bone run in the cancellous spaces, the Haversian canals, and the canaliculi, and consequently it is into these pre-existing spaces that the exudation is poured. As in all inflammation, this exudation, or lymph, consists of cells and fibrin, and, as elsewhere, the lymph is subsequently vascularized, and forms what has already been called "interstitial granulation tissue" or "inflammatory new formation." The next step in most cases of osteitis is **rarefaction,** or thinning of the osseous structure. This is not, as was formerly supposed, the result of a mechanical expansion or dilatation of the bone-spaces by the mere pressure of the contained exudation, but is the result of the absorption and destruction of the bone itself by the exuded leucocytes which lie in contact with it. The walls of the canaliculi, Haversian canals, and cancellous spaces are eaten away by the

blood-cells, so that their naturally smooth contour becomes pitted and irregular; in this process of absorption the leucocytes are aided by large giant cells, or osteoclasts, which are probably themselves formed from the white blood-cells. As the eroding process goes on, the bony substance becomes thinned away, or rarefied, and the cancellous spaces become larger, not alone on account of the greater tenuity of their walls, but also because, where the osteitis is most advanced, several spaces are thrown into one by the complete removal of their boundaries. (See Fig. 42.)

A section of a bone in this stage of osteitis therefore reveals greatly increased vascularity, rarefaction of the osseous tissue, complete filling up of the spaces in the bone by red gelatinous masses of granulations, and softening of the bone itself, so that it may often be readily cut with a knife or broken down with the finger-nail. The compact bone is no longer so dense, and its laminæ appear to be separated from each other. The cancellous spaces are so greatly enlarged that irregular cavities filled with soft pulp are formed, and the whole bone may be reduced to a mere shell. If the surface of a bone be the seat of osteitis, the smooth, compact tissue will become porous, rough, and pitted from erosion by the leucocytes, and the periosteum will be partly separated by the inflammatory exudation.

FIG. 42.

Section of an Ilium, showing Rarefaction. The laminæ of the compact bone appear to be separated from one another, the cancellous spaces are enlarged, and in the lower part of the specimen an irregular cavity has been formed by destruction of the bone which formerly bounded the cancellous spaces.

The further progress of a case of osteitis depends much on its cause and on the general health of the patient. Supposing *that the cause has* been an injury and that

the patient is healthy, the rarefaction will seldom or never proceed to such an extent as that described above, and, if the injury has been but slight, **resolution** and absorption of the exudation will occur. If the osteitis has progressed further, organization of the inflammatory products, with resulting **sclerosis**, is the most usual termination.

This process of sclerosis is precisely analogous to that of scarring in the soft parts. The cells of the granulations which occupy the cancellous spaces, Haversian canals, &c., become developed into connective tissue and finally into bone, the newly formed blood-vessels shrink and disappear, and the whole of the previously rarefied bone is converted into dense osseous structure, with fewer and smaller cancellous spaces than were present before the inflammation commenced. The inflammatory exudation which has collected beneath the periosteum also ossifies, and the bone is thickened by the formation around it of a layer of new bone formed for the most part in stalactitic or needle-like projections—an arrangement which results from the exudation collecting around the blood-vessels as they pass from the periosteum to the shaft.

Instead of terminating in sclerosis, osteitis may result in **suppuration.** This may occur in even the most healthy subjects, and is perhaps most frequent when the inflamed bone is exposed and thus rendered liable to septic infection. It may, however, result from want of rest, the presence of some irritating foreign body, the extension of inflammation from other parts, or from the bad state of health of the patient.

Whatever the cause, the disintegration of the bone by the interstitial granulation tissue progresses to such an extent that, finally, instead of the cancellous spaces being occupied merely by granulations, they are filled with pus. Similar changes occur on *the surface,* and pus is discharged from a granula-

ting surface of inflamed bone, just as it might be from an ulcer in the soft parts. The pus having been discharged, and the cause of the inflammation removed, suppuration will cease, unless some constitutional condition causes it to continue. Lastly, organization, with resulting sclerosis, will terminate the process, just as scarring and contraction of the cicatrix terminate the process of ulceration in the soft tissues. In many cases of osteitis, suppuration and sclerosis co-exist; thus, in deep ulcers of the leg, the tibia may be exposed and suppurating at one part, whilst the bone around is sclerosed and thickened.

It is to suppurative osteitis, with destruction of bone, such as is above described, that the term **caries** is often applied. Caries, however, is now rather a clinical than a pathological expression, and is used to signify inflammation of bone with rarefaction alone, as well as with suppuration, whilst by some authors it is limited to that form of osteitis which is called strumous. I myself think that, whilst the term caries is useful from a clinical point of view as expressing all forms of osteitis with destruction of bone, it is not advisable to employ it in a pathological work, on account of the various meanings which it has for both teachers and students.

FIG. 43.

Section of Portions of the Tibia and Femur in a case of Strumous Osteitis. The cancellous spaces are enlarged, and are in part filled by opaque masses of caseous matter.

In **strumous osteitis**, as in other strumous or scrofulous affections, there is a special tendency to caseation of the inflammatory products, as well as to a low and chronic form of suppuration; there is also little or no tendency to repair, or to arrest of the inflammation.

In such cases the inflammatory exudation in t cancellous spaces becomes converted into a soft pu mass of caseous matter and pus, and in the m typical examples there is no sign whatever of the for tion of new bone, no appearance of sclerosis, none repair. In this way, bones affected with strum osteitis may be hollowed out into mere shells—a c dition which is best exemplified in the small bones

FIG. 44.

Section of a Bone from a case of Strumous Osteitis. The osseous tissue has been in great part destroyed, and its place taken by leucocytes. The remains of bony trabeculæ in process of destruction may be seen, and in the centre of the section is a caseous mass formed around a giant cell. (Crouch, $\frac{1}{8}$ inch.)

the carpus and tarsus. In some cases minute port of the osseous tissue necrose, and small sequestr soft and crumbling bone are discharged with the The name of "caries necrotica" has been applie this condition.

If a bone in a state of strumous osteitis be amined microscopically, it will be found that the cess is essentially tubercular, and that tubercle

tubercle bacilli are mingled with the inflammatory exudation which fills the osseous framework. In most cases the bacilli are very few in number and difficult to demonstrate, though inoculation with the tissue in which they lie will cause tubercle in animals, and will be followed by the growth of the bacilli in larger numbers.

Strumous osteitis is most common in cancellous bone, and is seen especially in the articular ends of the long bones, in the carpus, tarsus, and bodies of the vertebræ. It is also one of the most common causes of strumous or tubercular disease of joints, for the process is essentially infective, and tends to spread to the tissues in the neighbourhood of the inflammatory focus.

A large proportion of cases of strumous osteitis terminate in suppuration. The abscesses, at first chronic, are liable, after discharging their contents, to become septic, and to form pus in large quantities. Many patients consequently die of hectic fever, of amyloid disease, or of general tuberculosis.

Abscess in bone.—Acute abscess never occurs in bone, for acute inflammations, which in the soft tissues would terminate in the formation of abscess, would in bone be sure to cause necrosis. Abscess in bone is, then, always chronic, and of slow formation.

The patients in whom these abscesses occur are always young, the most common age being between twelve and twenty. The bones most commonly affected are the tibia and the femur, and in these two bones, indeed, the larger number of all the recorded cases will be found. Chronic abscess is never met with in the shafts, but always in the cancellous tissue of the epiphysial ends.

The most probable cause of an abscess is an injury which excites an inflammation of the cancellous tissue. Rarefaction of the bone ensues, the walls of the cancellous spaces are destroyed, and thus a cavity is gradually formed in which the inflammatory products

accumulate. As in the soft parts, the abscess-cavity soon becomes surrounded by newly formed tissue, the result of a process of chronic inflammation, and thus the bone around the abscess becomes thickened and sclerosed. So long as the pus remains, the inflammation continues, and more and more new bone is produced from the superjacent periosteum. If, however, as is so often the case, the abscess is situated near to a joint, it is not shut in on this side as elsewhere by periosteal thickening, for, there being no periosteum in this situation, new bone is never produced on an articular surface, and thus, if the abscess continues to extend, the pus is more liable to be discharged into the joint-cavity than elsewhere, and to cause suppurative arthritis.

FIG. 45.

The Lower End of a Humerus, showing an abscess which has burst into the elbow-joint.

In addition to the thickening of the bone itself, there is frequently thickening of the soft parts, and a gradual extension of the inflammatory process to the skin, with resulting œdema and reddening. Pain is tolerably constant, but, except at intervals, is not severe. There is generally a good deal of tenderness on pressure, and, on account of the proximity of the neighbouring articulation, attacks of synovitis, with effusion into the joint-cavity, are of frequent occurrence.

In some cases the formation of pus in the cancellous tissue is accompanied by necrosis of portions of the surrounding bone. Such cases, however, are much more acute than are those of simple abscess,

and the danger of implication of a joint is much greater. Reference will again be made to these in the chapter on Diseases of the Joints, under the heading of "Acute Epiphysitis."

Osteomyelitis.—Osteomyelitis is a term which is best limited to diffuse inflammation of the lining membrane and the medulla of a bone, with implication of the surrounding cancellous tissue. Such a diffuse inflammation is always of a septic origin, and is closely allied to cellulitis of the soft parts. It always originates in a wound which exposes the cancellous tissue or medulla, such as an amputation wound or a compound fracture. Osteomyelitis is characterized by the rapid formation of pus, which infiltrates the neighbouring cancellous bone, and is liable to extend along the whole length of the shaft. The inflammation extends not only in a longitudinal direction, but also through a varying thickness of the surrounding osseous structure, and may even reach the surface and affect the periosteum. An examination of a bone in a case of osteomyelitis reveals the following conditions:—The surrounding soft parts are inflamed, œdematous, and often sloughing. The periosteum is usually retracted from the bone in the neighbourhood of the wound, whilst from the medulla protrudes a soft mass of sloughing tissue. On section, the medullary canal is found filled with a similar material, composed of pus, broken-down medulla, and disintegrating bone. The cancellous spaces contain the products of inflammation in various stages of decomposition. The disease almost always results in necrosis, and the amount of dead bone is sometimes very extensive.

As has already been said, osteomyelitis is essentially a septic process, and, in consequence, there is often very considerable constitutional disturbance. Many patients die of pyæmia.

In some cases the inflammation becomes limited, and does not implicate the whole length of the shaft; and, indeed, it may be said that examples of diffuse

osteomyelitis become more rare every day—a circumstance which is due to the improvements in the modern treatment of wounds.

DIFFUSE PERIOSTITIS.

The term "diffuse periostitis" is misleading, for the periosteum alone is never affected. In diffuse periostitis there is a spreading, septic inflammation both of the periosteum, and of a varying thickness of the subjacent bone. The disease is essentially one of early life, and hardly ever occurs in adults.

The subjects of acute periostitis are often in an unhealthy condition at the time that they meet with the slight injury or the exposure to wet and cold which are the almost invariable causes of this affection. Occasionally, acute periostitis occurs during convalescence from one of the specific fevers.

As might be expected, the bones of the lower extremity, being the most exposed to cold and injury, are more frequently attacked than are those of other parts; the tibia and the lower and posterior part of the femur are most often involved. The humerus and clavicle seem to be more frequently attacked than the bones of the forearm.

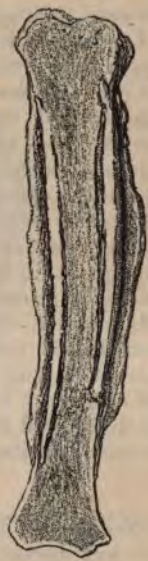
It is probable that the local condition of certain parts of some of the bones further predisposes them to attack. Thus, the anterior surface of the tibia and that part of the femur which lies in the popliteal space owe their liability to acute periostitis to the fact that, on account of the absence of all muscular attachments, they are much less vascular and less protected than are those portions of the same bones, which are closely covered by muscle. In some cases many bones are simultaneously affected.

The disease commences with local pain and swelling. The skin at first is not implicated, but soon becomes red and œdematous. Constitutional disturbance is generally marked, the temperature runs up to 103° or 104°, and rigors, vomiting, or convulsions

may occur. The local swelling increases, and spreads along the bone, and in bad cases which are not subjected to treatment the inflammation may extend over the whole length of the shaft. Pyæmia is a very common complication.

An examination of the bone itself will reveal the following conditions:—The periosteum and the subjacent bone at first show the usual vascularity which marks the onset of inflammation. Very soon there is exudation, and pus is quickly formed. The pus infiltrates the looser and more cellular part of the periosteum, and extends from it into the soft tissues. It collects, however, in the greatest quantity between the periosteum and the bone, for here there is most room for it, and the periosteum is thus separated from the shaft to a variable extent. If the disease progresses, the stripping up of the periosteum may extend as far as the epiphysial cartilage. Beyond this it seldom extends, on account of the close attachment of the periosteum in this situation; and, for the same reason, and on account of the difficulty the effusion has in making its way through the tough periosteum, the pus may extend between the epiphysial cartilage and the shaft, and may thus separate the one from the other.

FIG. 46.



A Tibia from a case of Acute Periostitis. The periosteum has been separated from the shaft, and the greater part of the latter has necrosed.

Meanwhile, the inflammatory process also extends into the bone, and acute osteitis progresses as rapidly as *does the periosteal inflammation.*

The inflammation usually fails to reach the neighbouring joints, partly on account of the close attachment of the periosteum at the epiphysis already mentioned, and also because the non-vascular epiphysial cartilage offers considerable resistance to the extension of the inflammatory process. Occasionally, however, the suppuration does involve the articulation, and sets up in it a most acute and destructive form of suppurative arthritis. If an exit is not provided for the pus, the latter will become diffused amongst the muscles, and will ultimately make its way through the skin by numerous apertures. If the pus be evacuated early, the disease may be cut short, and in favourable cases the bone recovers without necrosis. The extent to which the bone dies in any case depends not only on the separation of the periosteum, and the consequent interference with the blood-supply, but also, and probably to a far greater extent, on the inflammation of the bone itself. Acute osteitis is the most fertile cause of necrosis, and the greater the amount of bone inflamed the more extensive will be the necrosis. The separation of the dead bone from the living, and the formation of new bone occur in the manner described below.

NECROSIS.

Necrosis of bone is the equivalent of gangrene of the soft parts, and, like the latter, it arises from interference with the blood-supply.

Necrosis most frequently results from injury and acute inflammation. In some cases of the former, the periosteum is torn away, and thus the bone is deprived of a considerable proportion of its blood. Such an injury is always followed by a certain amount of thrombosis in the torn blood-vessels, and, later on, by inflammation of the damaged tissues. Both of these tend to further interfere with the circulation.

In acute inflammation of any part of the body, *the*[illegible]dency to the compression of the vessels

y the inflammatory exudation. The more acute the
flammation the greater is this tendency, and the
ore dense and unyielding the inflamed structure
ie greater is the tension of the extravasated fluid.
1 bone, the exudation is poured out into the
ncellous spaces and the Haversian canals, and, in
ses of acute osteitis, the blood-vessels are very
ickly compressed by the pent-up exudation. In

FIG. 47.

Portion of a Femur from a Stump. The lower inch of the bone is necrosed, the periosteum and the soft tissues are quite detached from it, and a line of demarcation has been formed between the dead and the living bone.

ss acute cases, where the process of exudation is
uch slower, time is allowed for enlargement of the
ny canals by absorption of their walls by the
ucocytes, and thus more space is provided for the
uded fluid, and necrosis does not result. Again,
crosis is more common in compact than in can-
llous bone, for in the latter there is more room for
ie exudation, and consequently there is less tension.
The amount of bone which dies in any individual

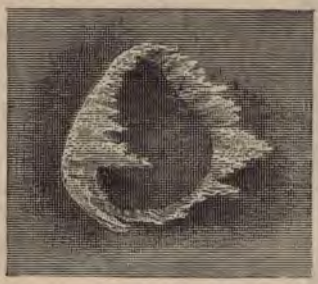
case depends chiefly on the extent of the osteitis, or, in cases of injury, on the extent of separation of the surrounding soft parts. In many instances these two causes are combined. Thus, in compound fractures the bone may be comminuted, and the fragments almost completely separated from the neighbouring tissues, whilst, on account of the extent of the injury, the resulting inflammation is proportionately great. When the periosteum is separated, and the superficial bone is alone injured, a thin shell of bone may alone die, whilst, in cases of diffuse periostitis and osteomyelitis, either the whole thickness or even the whole length of the shaft may perish. Necrosis of bone after amputations affords another example of the effect of injury. In these cases the inflammation which results from the sawing, and often from subsequent septic conditions, causes the death of a ring of bone which, though commonly very small, is in some cases an inch or more in depth. Under these circumstances, the stump refuses to heal, for the dead bone acts as a foreign body, and, if an examination is made, the periosteum will be found separated from the necrosed extremity, which in time is separated and cast off. (See Fig. 47.)

Separation of the dead bone.—When bone is dead, the living bone in contact with it soon shows signs of irritation. It becomes the seat of inflammatory changes, just as do the soft tissues in a case of gangrene; the inflammation progresses to ulceration, granulation tissue is formed, and the living bone is separated from the dead by a "line of demarcation." This process of separation is necessarily a slow one, and, where a considerable thickness of bone has to ulcerate through, many months may elapse before the process is complete. So long as the necrosed bone is in contact with the granulations of the neighbouring healthy bone, it is in part destroyed by the latter, and is eaten out and deeply pitted by the destructive action of the leucocytes. Consequently, if a piece of

dead bone be examined, its under surface will be found rough and indented, and marked by numerous little pits or depressions which were once occupied by granulations. (See Fig. 48.) The surface of the dead bone is non-vascular and is usually white, but occasionally, from exposure to the air, it becomes blackened.

The dead portion of bone when separated from the living is called a "sequestrum," and under favourable circumstances may be cast off from the body; the ulcerated surface of bone left behind will then

FIG. 48.



A Ring of Necrosed Bone which has separated from a Stump.

heal. If the necrosed bone is quite superficial, the process of shedding is called "exfoliation." This is most commonly seen in the bones of the skull, where destruction of the pericranium by mechanical injuries, or by burns, often results in death of the outer table alone, the inner table being supplied with blood from the dura mater.

Formation of new bone and inclusion of the sequestrum.—It has already been said that the separation of the dead from the living bone is the result of an inflammatory process. Now, this inflammation is not limited to the immediate neighbourhood of the *necrosed bone, but* extends over a considerable

area. The living bone in contact with the sequestrum suppurates, but the osteitis set up around is less acute, and results in the formation of new bone. The latter is formed not only by interstitial deposit, but also, and probably to a greater extent, by the neighbouring periosteum and the surrounding soft parts. The amount of new bone formed may be very great, and it thus happens that, by the time the dead bone has become completely separated from the living, it is surrounded by a case of new bone of considerable thickness, and its extrusion or exfoliation is prevented.

FIG. 49.

A Tibia, showing necrosis of the shaft and formation of periosteal new bone.

This formation of new bone is often well seen in cases of acute periostitis where, a considerable length of the shaft having been destroyed, the sequestrum becomes surrounded by a sheath of new and porous bone, except at one or two places where discharging sinuses open through apertures in the new bone on to the skin surface of the limb. These apertures in the bony sheath are called "cloacæ," and occur in places where the periosteum has been previously destroyed by sloughing. But, although such a replacement of dead bone by newly formed osseous structure is often most useful in restoring the functions of the part, it is not without its *disadvantages*. In the larger number of cases the

sequestrum becomes so much shut in that its extrusion by natural means is impossible, whilst, so long as it remains, suppuration is kept up, chronic osteitis and periostitis persist, and the case of new bone becomes thicker and thicker. In cases where this thickening occurs at the articular end of a bone, it may be so extensive as ultimately to limit the movements of the joint, and the latter may become anchylosed by an extension to it of the inflammatory changes in progress in the parts around. It is evident, therefore, that it is advisable to remove the sequestrum as soon as it has become sufficiently loose; but it is not well to anticipate matters by artificially separating the dead bone from the living, for the reasons that, until the line of demarcation appears, it is not possible to be sure of the extent of the necrosis, and that, if the dead bone be removed, the formative periostitis will soon cease, and the production of new bone will be arrested. Where large portions of the shaft have been destroyed, such a failure to form new bone may result in the permanent impairment of the functions of the limb.

Perhaps the most troublesome cases of all are those of central necrosis—cases which depend apparently on a limited osteomyelitis—for in these the bone which dies is that which bounds the medullary canal, and from the beginning it is shut in by the superjacent compact bone.

Necrosis without suppuration.—Mr. Morrant Baker has drawn attention to the occasional occurrence of necrosis without external suppuration, and the subject is one of so much importance that it is well worthy of consideration.

In cases of this kind a history of injury may or may not be obtained, and the attention of the patient is attracted by a swelling on a limb, which increases in size with some rapidity, and as often as not is painless, and not even tender when examined. The superjacent skin may be reddened, but is sometimes quite natural.

The swelling feels firm and often elastic. The accompanying drawing of a femur is from a case of this kind. The patient was a lad of nineteen, who for about three months had noticed such a swelling as I have above described; it was painless, and increasing in size. The case was diagnosed as either one of periosteal sarcoma or of necrosis without suppuration, and it was decided to make an exploratory incision to settle the question. This accordingly was done, and a mass of soft, gelatinous tissue was exposed, which, in the opinion of those present, was of a sarcomatous nature. Amputation was accordingly performed. A section of the bone after removal showed that a very small portion of the compact tissue of the shaft had become necrosed, and that it had been subsequently shut in by a quantity of new bone formed around. Outside this new bone was a mass of fibrous tissue and infiltrated muscle, the section of which had simulated that of a sarcoma. The size of the swelling was altogether out of proportion to the amount of the necrosis; about twenty or thirty drops of pus lay around the sequestrum, and communicated by a minute aperture in the new bone with a tiny cavity in the inflammatory tissue.

FIG. 50.

Section of a Femur, showing excessive formation of new bone, and thickening of the soft tissues around a small sequestrum.

This case well illustrates the chief difficulty in the diagnosis of this form of necrosis, for, although the

true nature of the case was suspected, even a free incision rather obscured than cleared it up.

In addition to those forms of necrosis which result from injury, or from inflammation started by either mechanical or septic agents, it is necessary to allude to the necrosis which results from **chemical poisons.** Of these there are but two whose influence is of importance—mercury and phosphorus. They act differently, for the former causes necrosis through its absorption into the system, whilst phosphorus acts locally upon the jaw-bones through the inhalation of its fumes with the respired air. The effect of mercury on the teeth and gums is well known, and its implication of the jaw-bone is but an extension of the same influence to deeper structures. With very rare exceptions, phosphorus, when taken internally, does not cause necrosis, and its fumes may also be safely inhaled if the teeth are in a sound state. If, however, there is dental caries, a low form of persistently spreading osteitis and periostitis is started which often results in necrosis of considerable portions of the maxillæ. The separation of the sequestrum and the formation of new bone do not differ from similar processes in other parts.

CHAPTER XXXIV.

DISEASES OF BONE—(*continued*).

SYPHILITIC DISEASES OF BONE.

DISEASE of the bones is one of the commonest manifestations of constitutional syphilis, and may occur either early or late in the course of this affection. In the early stage of secondary syphilis pains in the bones, which are worse at night, are of frequent occurrence, and, although actual disease is not always to be discovered in a patient with these symptoms, the formation of nodes is very common.

A node is a localized inflammatory swelling on a bone. The commonest situations of such swellings are the long bones, especially the tibiæ, and the bones of the skull. A section of a node exhibits inflammatory exudation into and beneath the periosteum, as well as into the surface layers of the bone itself. In a large number of instances much of this exudation is subsequently absorbed, and the bone is restored to its natural condition, but in other cases, especially if proper treatment be not adopted, the exudation undergoes organization, firstly into fibrous tissue, and subsequently into bone, and a so-called "hard node" is formed. The new bone is generally rough and porous, like new bone elsewhere.

The tendency to organization, however, is dependent both upon the constitution of the patient and also on the locality of the node. If the patient be otherwise *healthy*, and the node be on a long bone, organization is

likely to ensue, but if the patient be broken down in health, and especially if the skull be the seat of inflammation, suppuration is liable to follow, and a "soft node" is produced. In this case a small periosteal abscess is formed, which, when opened, is found to be connected with a carious condition of the subjacent bone, and indicates that there has been a localized suppurative periostitis and osteitis, with rarefaction and partial destruction of the superficial layers of bone.

But whilst nodes are of common occurrence, they can scarcely be reckoned as serious lesions, when we consider how much more severely the bones may suffer in syphilis. For, instead of there being but one or two isolated nodes, the whole length of a bone may be attacked by chronic osteitis and periostitis, resulting in the formation of new bone, deformity of the limb, and great pain. In other cases, again, this sclerosis may be accompanied by caries and necrosis, and discharging abscesses and sinuses may tend still further to damage the health of the patient. The necrosis is chiefly caused by the cutting off of the blood-supply by the pressure of the inflammatory exudation, but is also attributed by some authors to the obstruction to the circulation which is caused by the sclerosis of the surrounding osseous structure. It is difficult to exaggerate the extent to which a bone may be damaged; caries, necrosis, sclerosis, and formation of stalactitic periosteal growths may so alter it as to render it almost unrecognizable.

It is, however, in the bones of the skull and face that syphilis is seen at its worst, for here the destructive processes far outrun those which cause mere sclerosis and osteophytic growth. Ulceration extending from the nasal or buccal mucous membrane may implicate the hard palate, and the bones and cartilages of the nose. Much of the latter organ may be destroyed, and perforation of the palate may cause difficulty in swallowing, with tendency to the return of fluid *through the nostrils*, and nasal intonation of

the voice. Inflammation of the middle ear may c necrosis of the auditory ossicles and of the temp bone, and thus produce deafness, or, by an exter of inflammation, may cause meningitis or suppur in the brain itself.

The vault of the skull is perhaps the favourite of syphilitic inflammations. Here the disease attack either the inner or the outer table, and in s cases implicates both. Caries and necrosis go han

FIG. 51

Calvaria with extensive Syphilitic Ulceration. The frontal bone is perforated in several places.

hand, portions of bone being first ulcerated, and t gradually cut off from their vascular supply by extension of the ulceration.

Three varieties of syphilitic ulceration of the s have been described—the annular, the tubercul and the reticulated. In the annular form the u ation commences at one spot and spreads eccc cally from this as a focus. The bone becomes w eaten and pitted, a circular groove is then fo around, and the central ulcerated portion is sepa

. its vascular connections, and dies. In the reti-
ed variety there is a network of periosteal new
, which is subsequently destroyed by annular
s, such as those above described. In the tuber-
ed ulceration there is first the formation of
d, rounded, tubercular nodules of new bone, and
quently an ulceration and destruction of them.
ese varieties of ulceration frequently co-exist in
same patient, whilst the amount of necrosed
differs much in different cases. The meninges
ot usually become inflamed, and the brain itself
rise escapes. Such, however, is not always the
for death may ensue from suppurative meningitis,
to an extension of inflammation from the carious
. (See also Congenital Syphilis.)

RHEUMATIC AFFECTIONS OF BONE.

ie most commonly recognized form of rheumatic
se of bone is a chronic periostitis, with thicken-
nd the formation of so-called "rheumatic nodes."
e nodes are usually situated upon the long bones,
are frequently indistinguishable from those due
philis. They never suppurate, however, and are
times more diffused than the syphilitic variety.
affections of the articular ends of the long bones
teo-arthritis will be described in the chapters on
ses of the Joints.

OSTEITIS DEFORMANS.

is is a form of very chronic inflammation of
occurring in people past middle age, implicating
bones, and accompanied by a peculiar softening
pending of the osseous structure. It was first
ibed by Sir James Paget.
e bones affected by this disease become gradually
ened by the deposit of new bone from the peri-
m, and by the same process their normal outlines
owly obliterated. By the exudation of inflam-
y products within the bone the osseous structure

is absorbed, rarefied, and softened, the spaces thus formed being filled with inflammatory exudation. The whole bone becomes greatly increased in circumference, and, on section, is seen to be much thickened. In some cases the medullary canal is increased in size.

In consequence of the softening which accompanies the inflammatory process the bones become bent, the normal curves being at first increased, whilst, after a time, fresh curvatures are developed.

FIG. 52.

Section of a Tibia from a case of Osteitis Deformans.

The skull is increased in thickness, the forehead becomes large and prominent; and the face in consequence appears to be too small for the cranium, by which it is overshadowed. The clavicles become much curved and thickened. The thorax falls in on account of the yielding of the softened ribs, and the abdomen becomes prominent. The femora curve chiefly outwards, and the tibiæ forwards. The humerus does not curve so much as most of the long bones, but the radius and ulna curve backwards. In consequence of the bending of the bones of the lower extremity, and of the general posterior curvature which is often met with in the spine, the height of the patient is frequently diminished by several inches. The walk is tottering, and the support of a stick is often necessary. The shoulders fall forward over the chest, and the head protrudes in a very peculiar manner, looking as though it was too heavy for the cervical vertebræ, for the chin would naturally rest upon the sternum, and, in order

to look up, the patient thrusts it out so that the face is carried on a plane which is considerably anterior to that of the body. The course of the disease is slow, and usually extends over many years. A fatal termination may result from the difficulty of respiration caused by the softened thoracic wall.

The disease has no known cause, and no remedial measures of any importance have been discovered. It seldom occurs before the age of forty, and is most common in males. It has been associated with gout in some patients, and with malignant tumours in others, but no causative relation with either of these has been established.

MOLLITIES OSSIUM.

Mollities ossium is a disease in which there is a gradual softening and subsequent bending of the bones. Many parts of the skeleton are usually involved at the same time, and the diseased condition affects the whole of the bones both of the limbs and of the trunk. Women of middle age are infinitely more subject to mollities than are men, and in a large number of cases it undoubtedly commences during pregnancy. In some patients mollities is limited to the pelvic bones. No time of life is altogether exempt, and examples have been recorded in infants as well as in extreme old age. In some few cases the course of the disease has been arrested either by nature or, apparently, by treatment.

An examination of the affected bones shows a gradual destruction of the cancellous tissue, with a corresponding increase in the medulla; the destruction extends to the compact bone, the osseous structure is gradually removed, the bone becomes soft and yielding, and, but little of its animal matrix remaining, it is in great part decalcified. In the process of destruction there is no sign of inflammation or of new growth; the bone salts appear to be simply dissolved out. An examination of the medulla shows, in some cases, an

increase of fat, and in others a peculiar gelatinous matter which is chiefly composed of oil, fat, and disintegrated blood-cells. The osteoclasts which are always present during bone destruction from any cause are here also increased in number.

The true pathology of mollities is yet obscure. It has been attributed to an excess of lactic acid in the blood, but this has certainly not been clearly demonstrated. When occurring during pregnancy, it has been attributed to the demand by the fœtus for bone salts; but this does not explain the cases which occur independently of pregnancy. In some cases the disease has been associated with the growth of malignant tumours in other parts of the body, and it has been suggested that mollities itself is nothing more than a diffuse tumour growth. Very little reflection is required to dispose of this theory. Lastly, mollities has been attributed to some influence of the nervous system, but what it is, or how it acts, is quite obscure.

RICKETS.

Rickets is a constitutional disease in which the bones are specially liable to suffer; they are not the only tissues diseased, but, on account of the very obvious changes that occur in their shape and structure, and of the importance of these changes in the further development of the body and limbs, the diseased state of the bones attracts attention rather than the constitutional cachexia and the visceral disease which accompany it.

Rickets is never congenital (the so-called cases of congenital rickets being properly referred to sporadic cretinism), but is chiefly due to bad feeding, although any bad hygienic conditions, such as overcrowding, deficient ventilation, &c., undoubtedly influence its development. Under the head of bad feeding is to be included, not only deficient quantities of food, but the ingestion of food which is not readily assimilable, *or is likely* to set up gastric or intestinal catarrh;

thus, the feeding of young infants with starchy material, such as biscuits and bread, is extremely harmful.

Rickets is most commonly developed during the first two years of life, but may occur as late as seven or eight years of age, whilst isolated cases are recorded in patients of twelve or fourteen. Children in towns are more frequently affected than are those in the country, and for obvious reasons. The general signs of rickets, independently of the osseous affections, are briefly as follows:—The child is liable to attacks of vomiting and of diarrhœa, its food evidently causes dyspepsia, and the abdomen becomes considerably swollen. There is much lassitude, with unwillingness for exertion and impairment of muscular power and tenderness of the limbs. At night the child sweats much, especially about the head, and often throws off the bed-clothes. The teeth are late in being cut, and the anterior fontanelle remains open for an undue length of time. The liver, spleen, and lymphatic glands may become enlarged, and laryngismus stridulus or bronchitis may occur as complications.

As regards the bones, the following changes may be noticed:—The long bones become excessively curved, the bending being at first due to an exaggeration of the normal curves, although, later on, secondary curves are developed. The articular ends of the long bones become swollen at the line of junction of the diaphyses with the epiphysial cartilages, whilst similar swellings developing at the sternal extremities of the ribs produce the so-called "beads" on the latter bones. On account of its softened state, the thoracic wall fails to resist the negative pressure established within the thorax during the act of inspiration, and its upper part becomes compressed against the yielding lungs; the lower portion of the thorax is not thus driven in, being supported by the solid liver and spleen and the other abdominal viscera. The spine becomes *more curved than* natural, and in some cases

a general posterior curve takes the place of the normal sinuous outline. The head is enlarged, and the forehead especially is bulging and prominent.

The pelvis is either compressed in an antero-posterior direction by the weight of the body being transmitted through the spine and the sacrum when the patient occupies a sitting posture, or else is flattened from side to side by the pressure of the heads of the femora when the patient is supported on the lower extremities. Thus, the former deformity is more common when the disease affects children unable to walk; the latter, when older patients are attacked.

Rachitic children are generally undersized, though they may be fat and flabby, and in bad cases the bone disease appears to act as a deterrent to future healthy growth, for a patient who has suffered severely from rickets seldom attains middle height. In consequence of the softened state of the bones, greenstick fractures are not uncommon.

An examination of the bones themselves after removal from the body shows that the osseous lesions above described are due to an imperfection in the calcification of the growing bone, and that, whilst the removal of old bone and the formation of the animal matrix for the new bone both proceed normally, it is in the failure of deposit of calcareous salts in this matrix that the real osseous defect in rickets exists. There is not, on the one hand, an increased absorption of bone, nor is there, on the other, an increased preparation for ossification.

In the normal increase of a bone in thickness the more central portions of the cancellous structure are gradually removed by absorption, so that the medullary canal slowly, but constantly, increases in size. And in a healthy bone, just as fast as this hollowing out progresses within, so fast is new bone laid down by the surrounding periosteum, the proper proportions of the compact bone and of the medullary canal being thus maintained. Now, in rickets, the former part of

this process progresses quite naturally. The shaft is hollowed out from within in a perfectly normal manner. It is the formation of new bone from the periosteum that fails, and, as the old bone is gradually removed, layer on layer of the animal matrix of the new bone is certainly formed from the periosteum, but, being only imperfectly calcified, the shaft comes to be gradually formed of soft unresisting bone, and consequently

FIG. 53.

Section through the Line of Ossification of a Rachitic Bone, showing the irregularity of the rows of cartilage cells and the imperfect calcification. (Zeiss, A.)

becomes curved and deformed. It is seldom that all attempts at calcification are entirely absent; there is generally some attempt, however slight, and the result of this is the formation of an imperfectly developed bone from the periosteum, to which the name of "osteoid tissue" has been given.

At the epiphysial ends changes of a precisely analogous nature are found; here also there is growth with

imperfect calcification. The epiphysial cartilage in a normal bone is continually growing, but just as fast as it grows so fast does calcification extend into it from the diaphysis, and thus the cartilage itself never exceeds certain limits of size. Now, in rickets, the growth of the cartilage progresses just as it does in a normal bone, but calcification is slow and imperfect. It thus happens that in a section of a rachitic bone the epiphysial cartilage is found to be considerably in excess of that which is natural. Yet here also, as in the case of the formation of new bone from the periosteum, calcification is not absent, but only incomplete; consequently, the line of ossification, instead of being regular and even, becomes irregular and jagged; islands of calcareous material are found in the enlarged epiphysial cartilage, and portions of unaltered cartilage are left behind in the most recently formed new bone. Microscopical examination shows great irregularity in the rows of cartilage cells, and imperfectly formed bone. (See Fig. 53.)

The swellings at the junctions of the epiphyses with the shafts are now readily explained. The imperfectly formed new bone is softer than natural, and, being compressed between the epiphysis on the one hand and the diaphysis on the other, it bulges at the circumference, as would any other soft and yielding structure.

By most writers on the subject it is stated that in rickets there is "increased preparation for the formation of new bone," *i.e.*, increased growth of the epiphysial cartilage, and the increased width of the latter in rickets is by such observers considered to be the result of the increased growth, and not, as is above described, of delayed calcification. The question is one which is a little difficult to settle definitely, but it is on the face of it highly improbable that a disease which results from malnutrition would cause increased growth of any tissue. As a matter of fact, also, the *bones of such* patients, instead of being longer, as

uld be if the epiphyses grew abnormally fast, rter than natural, and it is well known that children are usually ill-developed and stunted. xceptional cases the bones in rickets undergo change, and, becoming greatly increased in ss, lose much of their natural shape. This, is considered to be the result of a tendency to ed growth, but should, in my opinion, be looked ather as the result of the rickets than as an al part of the morbid process. The thickening ably of the nature of a compensative hyper-, and is designed to support the weak and g bone, whilst, on account of the rachitic con- of the patient, all the new osseous tissue thus is porous and spongy, as already described.

r rickets has ceased, the bones commonly be- enser than natural, and growth is often arrested earlier age than usual. When the bone has rved, it is especially thickened on the side of the ity—a condition which evidently strengthens tends to prevent the curve from increasing.

rvy rickets.—This name has been given to a which, like rickets, arises from bad feeding, often associated with the latter affection. It is erized by effusion of blood beneath the perios- of one or many of the bones, together with rhagic extravasations in the soft tissues, spongy nd purpuric eruptions. The bones of the lower ity are more frequently affected than are those upper, and the effusions of blood are most n at the junctions of the diaphyses with the sial cartilages; in some cases separation of an sis occurs.

swellings caused by the hæmorrhage are quite metrical, and vary much in size from time to he disinclination to use the limbs is much more ble than in rickets, and there is frequently pain and tenderness. The disease is not uncom- fatal, and an examination of the bones after

death sometimes shows that the sub-periosteal hæmorrhage has been very extensive. Notwithstanding the separation of the periosteum, necrosis never ensues.*

FŒTAL RICKETS—SPORADIC CRETINISM.

Rickets is never a congenital disease, but the name of "fœtal rickets" has been introduced to indicate a condition of the skeleton which bears a superficial resemblance to true rickets. Infants and children the subjects of the disease in question are of stunted growth, with large heads, short and curved limbs, thick fat necks, and imperfect mental development. As they grow up, the face becomes broad and flat, the nose flat and thick, the lips heavy and pouting, and the expression dull and heavy. Puberty occurs very late, and the sexual organs often remain permanently undeveloped—a patient of five and twenty or thirty frequently looks no more than eight or ten years of age, whilst his cerebral functions are usually still less developed than is his body; many of these people are idiots. In some cases the thyroid gland is enlarged, in others it is absent, in others again it appears to be normal. The supra-clavicular fossæ are often occupied by diffused fatty growths. On account of the resemblance of the patients who are the subject of this disease to the cretins of Switzerland and Italy, the name of "sporadic cretinism" has been applied to this class of cases.

An examination of the skeleton shows the following changes:—The base of the skull is often short, and the basi-occipital and basi-sphenoid bones may be prematurely united; the vault of the skull is fully developed, and there is sometimes hydrocephalus. The clavicles (which, like the vault of the skull, are formed in membrane) are of normal length, as is also the vertebral column. The diaphyses of the bones of the extremities are very short, thick, and curved; in

* See a paper by Dr. Barlow in "Trans. Med. Chir. Soc." vol. lxvii.

some cases they are only represented by most minute portions of bone. The epiphyses are large and well formed. The sternal extremities of the ribs terminate in cup-shaped cavities, which surround the ends of their corresponding cartilages.

Microscopical examination shows an ingrowth of fibrous tissue between the epiphysial cartilage and the diaphysis, combined with the almost complete absence of all attempts at ossification. The true pathology of sporadic cretinism is uncertain, though, reasoning by analogy, it appears probable that it is dependent upon some alteration in the functions of the thyroid body.

CHAPTER XXXV.

TUMOURS OF BONE.

EXOSTOSES.

Exostoses, or osteomata, are the most common tumours of bones. There are two chief varieties of such growths—**cancellous** and **ivory.**

Cancellous exostoses are composed of cancellous tissue exactly similar in structure to that which forms

Fig. 54.

Section of a Cancellous Exostosis, covered with Cartilage, from the Femur.

the articular ends of the long bones. They occur almost invariably in young people, and are most commonly seen on the ungual phalanx of the great toe or at the articular ends of the long bones, especially *on the lower* and inner side of the femur just by the

adductor tubercle, and on the upper end of the tibia. They appear to grow from portions of the epiphysial cartilage which have failed to become ossified, and which subsequently take on active and independent growth. A section of a cancellous exostosis will always show a covering of cartilage, and microscopical examination will reveal the formation of new bone in progress, just as does a section through an epiphysial cartilage.

Cancellous exostoses seldom attain any considerable size, being most commonly about as large as a walnut. They usually cease to grow at the time when the epiphysis is united to the shaft—a point which is worth remembering when considering the advisability of removal. They are often attached to the bone by a distinct pedicle, and, especially when they have been subjected to pressure or friction, may be covered by a bursa, which may render their hardness less evident than would otherwise be the case. Occasionally, these bursæ are in direct communication with the neighbouring articulation.

Cancellous exostoses are sometimes multiple, and as many as one hundred or more have been known to occur on a single individual. These multiple exostoses are frequently hereditary, and are often found in several members of the same family. In their structure and mode of growth, as well as in their preference for the articular ends of long bones, they do not differ from the single exostoses.

Ivory exostoses are composed of compact bone of more than usual density, with fewer Haversian spaces and canaliculi than are present in normal bone. Like the cancellous growths, they are most common in young people, but occur also in middle age. The most usual situation for such tumours is the cranium, but they are also found on the bones of the face and on the ilium and scapula. They are usually single and small, often not larger than a hazel-nut. They are in *no way dangerous* to life, but, from their

situation, may be the source of much inconvenience, and, when growing from the bones of the orbit, may cause so much pressure on the eyeball as to seriously interfere with the sight, or even to destroy the eyeball itself. So great is the density and hardness of the bone of which they are composed that in some cases all attempts at removal by bone-forceps or saws have been frustrated.

The special forms of osteomata which grow in the jaws are described under "Tumours of the Jaw-bones."

ENCHONDROMA.

Cartilaginous tumours grow almost exclusively on the bones of the hand, and much more rarely on those of the foot and on the ribs. Pure enchondromata also occur at the articular ends of the long bones of the lower extremity, but most of the cartilaginous growths in these situations are mixed with sarcomatous elements, and should be classed amongst the malignant tumours.

Enchondromata of the hand are frequently multiple, and grow on the phalanges more often than on the metacarpal bones. In bad cases, the hand is completely disfigured and useless. The growth commences inside the affected bone, and expands the compact tissues so as to form a bony shell. Unless the tumour is of unusual size, it can be enucleated without sacrifice of the entire bone.

The cartilage of which these tumours is composed is almost always hyaline, but not infrequently the matrix shows in parts traces of fibrillation. Neither ossification nor calcification is frequent.

FIBROMA.

Fibrous tumours of bone are of limited distribution, and, indeed, appear to be almost confined to the nasal and buccal cavities. In the former they occur as *fibrous polypi*, and in the latter as fibrous epulides.

They spring from the periosteum in all cases, and are of an innocent nature.

CYSTS.

Cysts containing serous fluid, such as are met with in the soft tissues, are not found in bone, whilst mucous cysts, and others which occur in the maxillæ, are dealt with under "Tumours of the Jaw-bones." The only other fluid tumours met with in bone are of a parasitic nature, and contain hydatids. Cysts of this nature may attain a considerable size, expand the bone, and lead to its fracture. Their intimate structure does not differ from that of hydatids in other parts of the body. Secondary, or degeneration cysts, are common in the endosteal sarcomata.

SARCOMA.

Sarcoma is the only form of malignant tumour which occurs primarily in bone. Carcinoma cannot originate in osseous tissue, for its growth always commences in pre-existing epithelium.

Speaking generally, sarcoma of bone may be said to be a disease of early life, though not of infancy. By far the larger number of cases occur between the ages of fifteen and thirty, though examples are to be found in patients both older and younger than these limits.

Sarcomata are most conveniently divided into two main classes—those which grow outside the bone, or **sub-periosteal sarcomata,** and those which grow within, or **endosteal sarcomata.** The growth in either case may be composed of round, spindle, or mixed cells, whilst in the endosteal sarcomata, and very rarely in the periosteal ones, myeloid or giant cells are found. In all the varieties, chondrification, ossification, and calcification may occur, and thus, much of the growth may be composed of cartilage, bone, or calcareous material. Such an alteration in structure does not affect the clinical character of the tumour, or modify *its malignancy,* but the secondary growths, if

such be present, will closely simulate the primary tumour.

Some bones are much more frequently diseased than are others, those most commonly affected being the femur, tibia, humerus, the bones of the skull, and the lower jaw.

The **sub-periosteal sarcomata** originate in the periosteum, and separate it from the subjacent bone. As they increase in size, they extend through the periosteum and infiltrate the surrounding soft tissues, and, in addition, grow into the bone itself, and develop in the osseous structure even more rapidly than they do in the superjacent parts. They almost always occur at the articular ends, but in the humerus, and to a less extent in the radius and ulna, exhibit a tendency to affect the shaft. They present themselves clinically as firm, elastic growths on one aspect of the bone, not expanding it, and not being covered by a bony shell; their base of attachment is large, and frequently osseous; the diseased bone may spontaneously fracture. The skin is often red, shiny, hot, and tender; there may be effusion into the neighbouring joint, and the body temperature may be considerably elevated. The rapidity of growth differs in different cases, being generally more rapid in the round-celled tumours than in those which are composed of spindle

FIG. 55.

Section of the Lower Half of a Femur with a Periosteal Sarcoma. The outline of the shaft can still be traced, but the cancellous tissue and the medulla have been infiltrated by the growth.

cells, and whose stroma is often fibrous. If no operation be performed, the patient may die of the cachexia induced by the growth, or of secondary tumours in the viscera, especially in the lungs. If amputation of the limb be performed, the growth is exceedingly likely to recur, although, if the bone at the seat of section is healthy, recurrence is not frequent in the stump. The superficial lymphatic glands —*e.g.*, those in the inguinal region—often remain free from disease throughout; but the deeper ones—*e.g.*, those along the iliac vessels, or in the lumbar region—are somewhat more liable to be implicated by the secondary tumours. In some cases the viscera are largely involved.

An examination of the diseased limb will show a growth which infiltrates, but does not expand, the bone, and which is in no way limited by a capsule. The remains of the periosteum can often be traced, but in tumours of considerable size it becomes indistinguishable. The growth itself may either be a soft, pulpy, hæmorrhagic mass, or a gelatinous, opalescent, fleshy, and somewhat lobulated tumour; more rarely, it is fibrous on section. Mingled with the tumour is a variable amount of cartilage, bone, or calcareous matter. The bone is arranged in the form of delicate spiculæ or needles, standing out at right angles from the diseased shaft or articular end; this structure is best seen in macerated specimens, and is produced by the tendency to the formation of bone around the blood-vessels as they pass inwards from the periosteum.

Endosteal or central sarcomata grow almost invariably in the cancellous tissue of the articular extremities of the long bones, and hardly ever in the shafts. They are common also in the jaw-bones, and are met with, though less frequently, in those of the skull, carpus, and tarsus. Commencing in the cancellous tissue, they soon extend into and infiltrate the compact bone, and gradually expand it, and alter its shape. *The thinned* and expanded bone covers the

growth like a shell, whilst from the periosteum new bone may be produced to supply the place of that which is destroyed. Spontaneous fracture may occur in consequence of the weakening of the bone. As the tumour increases, it bursts through its osseous capsule in places, and infiltrates the soft tissues. The articular cartilage offers a stubborn resistance to its progress, and is seldom involved in the growth, although the latter may push it aside and reach the articular cavity. Endosteal sarcomata are of very variable consistence, and exhibit a great tendency to break down in their centres and form cystic cavities, which occasionally communicate directly with large blood-vessels, and are full of blood and tumour débris. The myeloid sarcomata are of a dark-red or maroon colour, and are more liable than the others to develop cystic cavities.

FIG. 56.

Section of the Head of a Tibia, which has been expanded by the growth of an endosteal, myeloid sarcoma. The tumour has broken down and formed cysts.

Endosteal sarcomata present themselves clinically as growths expanding the bone, and not appearing on one side alone, as do the periosteal tumours. They are covered by a bony shell, which sometimes yields to pressure, and bulges or crackles beneath the finger; occasionally, pulsation is produced by the communication between the vessels and the cysts. The growth of endosteal sarcomata varies in rapidity, the myeloid tumours growing most slowly and the round-celled ones most rapidly. If no treatment is adopted,

the patient may die either of the cachexia induced by the disease, or else from dissemination of the tumour. Glandular affection is rare. If completely removed by amputation or otherwise, myeloid sarcomata frequently do not recur either locally or elsewhere, and the tendency to recurrence and dissemination of all endosteal growths is much less than is that of the periosteal sarcomata.

TUMOURS OF THE JAW-BONES.

Tumours of the jaw-bones possess so many distinctive features that they merit separate description. These distinctive characters depend partly on the proximity of the neighbouring mucous cavities, and partly also on the presence of the teeth and of the fœtal structures from which the latter originate.

Epulis.—The term epulis is often applied without distinction to any tumour which grows upon the gum, but is best limited to the "hard fibromata" which are common in this situation. The common fibrous epulis usually occurs in young people. It presents itself as a rounded, slightly pedunculated growth, seldom larger than a hazel-nut, and often smaller. It does not bleed except when it is ulcerated, and gives but little pain. Such tumours grow from the periosteum, and are occasionally attached to the fang of a tooth. Even when not so attached, their deeper part often extends into the neighbouring alveolus, and consequently their complete removal generally necessitates the extraction of a tooth and the excision of a portion of the alveolar margin.

The so-called "diffuse epulis" is merely a general thickening and hypertrophy of the tissue of the gum.

Sarcoma.—Myeloid sarcomata are often included amongst the epulides under the name of "myeloid epulis." They possess the characters common to endosteal sarcomata in other situations—growing within and expanding the jaw-bones, presenting as rounded, tense, and *elastic swellings*, often feeling suspiciously

like cysts, and generally developing in young subjects. After complete removal, they seldom recur, and never become disseminated.

In addition to the myeloid tumours, other varieties of central sarcoma occur within the jaw-bones, and are most frequently seen in the antrum. They are usually composed of round or oval cells, are very soft and succulent, of rapid growth, tending to extend into neighbouring cavities, to fungate through the skin, to affect the lymphatic glands, and to become disseminated.

As they increase in size, they expand the wall of the antrum on all sides. Thus, they thrust inwards the outer wall of the nostril, and obstruct respiration; they push up the floor of the orbit and cause protrusion of the eyeball; backwards, they extend to the pharynx; and downwards, they either cause the hard palate to bulge, or else make their way between the two layers of compact tissue of the alveolar process, and, after loosening one or more of the teeth, fungate through the gums. Any tumour growing within the antrum tends to distend the cavity in this way, but malignant tumours do so in a more typical manner than do the innocent growths. Glandular affection is not common in cases of sarcoma of the antrum, but does sometimes occur.

In addition to the myeloid tumours, fibro-sarcomata occasionally develop within the lower jaw-bone. These are sometimes hard, and fibrous on section, and contain within their substance numerous osseous granules. They are apparently not very malignant, and, when completely removed with the bone in which they grow, do not seem prone to recur.

The periosteal sarcomata of the lower jaw do not present any important points of difference from similar tumours on other bones. They are mostly of rapid growth, and are very malignant.

Carcinoma.—True carcinomatous tumours are *met with* in the antrum, developing in this cavity

from the epithelium of its mucous lining. They grow in elderly people, and tend to run a rapid course, affecting the glands and becoming disseminated. Histologically, they are found to be either epitheliomata, or spheroidal-celled encephaloid cancers.

Multilocular cystic tumour.—The so-called multilocular cystic tumour appears to stand between the solid growths on the one hand and the true cysts on the other; on account of its structure, it is sometimes

FIG. 57.

A Lower Jaw-bone expanded and in part destroyed by a Multilocular Cystic Tumour.

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to make it appear that the jaw-bone is expanded merely by collections of dark, brownish fluid. Multilocular cystic tumours are most common in the lower jaw, and are of endosteal or central growth. They appear to originate in an ingrowth of the epithelium of the gum, and occasionally follow injury or caries of the teeth. The disease may occur at any period of life, but is most common between the ages of twenty and forty. Growth is generally slow, and five or ten

FIG. 58.

Section of a Multilocular Cystic Tumour of the Lower Jaw. The matrix is fibrous, and contains masses of epithelial cells, which are breaking down in their more central parts. (Zeiss, A.)

years may elapse before the patient applies for treatment. The tumours are not malignant, and show no tendency to affect the glands or to disseminate. They expand the jaw-bone, more especially on its inner side, and are frequently very hard and bony to the touch; they are occasionally elastic and crackling; the teeth become loosened, and fall out, and from their empty alveoli there may be a discharge of sticky fluid.

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steal cysts.—The periosteal cysts of the collections of fluid situated beneath the n of the fangs. They seem to be of inflam- rigin, and are generally connected with eth, or with fangs left behind after imper- uction. They vary in size from that of a walnut, and, when large, cause thinning of jacent bone. They are of common occur- d sometimes cause considerable pain.

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Such cysts are of a perfectly innocent nature, and may occur at all ages; they are not accompanied by, or dependent on, the development of any solid growth. In cystic disease of the antrum, this cavity is distended in the same manner as by a malignant tumour, but there is no fungation, growth is not rapid, and, as the bone is thinned, the presence of fluid becomes more apparent.

Dentigerous cysts. — Dentigerous cysts are cavities containing serous fluid, dependent upon impacted, misplaced teeth, *i.e.*, they are associated with some impairment of the normal process of dentition, resulting in the retention of the tooth or teeth within the alveolar process of the maxilla. With scarcely an exception, dentigerous cysts are formed in connection with the permanent and not with the milk teeth, and occur more frequently in cases of retention of the canine tooth than of any other. It by no means follows, however, that cysts result in all cases of retained permanent teeth.

FIG. 59.

Portion of a Dentigerous Cyst with a Tooth attached.

Dentigerous cysts are formed by a distension of the tooth-sac with fluid secreted by the epithelium of the enamel-pulp. Consequently, the crown of the tooth itself projects into the cavity of the cyst, just as it formerly did into its own tooth-sac, and its fang is fixed into the sac-wall. As the cyst enlarges, it expands the jaw-bone, and forms a rounded, elastic swelling, the thin bony covering of which often crackles beneath the pressure of the finger. In cases of undue retention of the permanent teeth, the milk teeth are very late in being cast, and an examination of the mouth will therefore show either that a milk tooth is retained in that part of the jaw where the

ls, and whose stroma is often fibrous. If no ɔration be performed, the patient may die of the ihexia induced by the growth, or of secondary nours in the viscera, especially in the lungs. If ıputation of the limb be performed, the growth is ɔeedingly likely to recur, although, if the bone at ə seat of section is healthy, recurrence is not fre-ent in the stump. The superficial lymphatic glands *e.g.*, those in the inguinal region—often remain se from disease throughout; but the deeper ones—*.*, those along the iliac vessels, or in the lumbar gion—are somewhat more liable to be implicated by e secondary tumours. In some cases the viscera are ɔgely involved.

An examination of the diseased limb will show a owth which infiltrates, but does not expand, the ne, and which is in no way limited by a capsule. ne remains of the periosteum can often be traced, t in tumours of considerable size it becomes indis-nguishable. The growth itself may either be a soft, ıpy, hæmorrhagic mass, or a gelatinous, opalescent, hy, and somewhat lobulated tumour; more rarely, is fibrous on section. Mingled with the tumour variable amount of cartilage, bone, or calcareous tter. The bone is arranged in the form of delicate culæ or needles, standing out at right angles from diseased shaft or articular end; this structure is t seen in macerated specimens, and is produced by tendency to the formation of bone around the blood-sels as they pass inwards from the periosteum.

ndosteal or central sarcomata grow almost ariably in the cancellous tissue of the articular remities of the long bones, and hardly ever in shafts. They are common also in the jaw-bones, are met with, though less frequently, in those of skull, carpus, and tarsus. Commencing in the llous tissue, they soon extend into and infiltrate ompact bone, and gradually expand it, and alter ape. The thinned and expanded bone covers the

growth like a shell, whilst from the periosteum new bone may be produced to supply the place of that which is destroyed. Spontaneous fracture may occur in consequence of the weakening of the bone. As the tumour increases, it bursts through its osseous capsule in places, and infiltrates the soft tissues. The articular cartilage offers a stubborn resistance to its progress, and is seldom involved in the growth, although the latter may push it aside and reach the articular cavity. Endosteal sarcomata are of very variable consistence, and exhibit a great tendency to break down in their centres and form cystic cavities, which occasionally communicate directly with large blood-vessels, and are full of blood and tumour débris. The myeloid sarcomata are of a dark-red or maroon colour, and are more liable than the others to develop cystic cavities.

FIG. 56.

Section of the Head of a Tibia, which has been expanded by the growth of an endosteal, myeloid sarcoma. The tumour has broken down and formed cysts.

Endosteal sarcomata present themselves clinically as growths expanding the bone, and not appearing on one side alone, as do the periosteal tumours. They are covered by a bony shell, which sometimes yields to pressure, and bulges or crackles beneath the finger; occasionally, pulsation is produced by the communication between the vessels and the cysts. The growth of endosteal sarcomata varies in rapidity, the myeloid tumours growing most slowly and the round-celled ones most rapidly. If no treatment is adopted,

nay die either of the cachexia induced by
or else from dissemination of the tumour.
ffection is rare. If completely removed
on or otherwise, myeloid sarcomata fre-
ot recur either locally or elsewhere, and
y to recurrence and dissemination of all
owths is much less than is that of the
comata.

TOURS OF THE JAW-BONES.

of the jaw-bones possess so many dis-
ures that they merit separate description.
ctive characters depend partly on the
the neighbouring mucous cavities, and
n the presence of the teeth and of the
res from which the latter originate.
-The term epulis is often applied without
any tumour which grows upon the gum,
imited to the "hard fibromata" which
in this situation. The common fibrous
y occurs in young people. It presents
rounded, slightly pedunculated growth,
than a hazel-nut, and often smaller. It
d except when it is ulcerated, and gives
n. Such tumours grow from the peri-
are occasionally attached to the fang of a
when not so attached, their deeper part
into the neighbouring alveolus, and con-
ir complete removal generally necessitates
a of a tooth and the excision of a portion
r margin.
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id hypertrophy of the tissue of the gum.
—Myeloid sarcomata are often included
epulides under the name of "myeloid
y possess the characters common to en-
nata in other situations—growing within
g the jaw-bones, presenting as rounded,
stic swellings, often feeling suspiciously

like cysts, and generally developing in young sul
After complete removal, they seldom recur, and
become disseminated.

In addition to the myeloid tumours, other va
of central sarcoma occur within the jaw-bone
are most frequently seen in the antrum. The
usually composed of round or oval cells, are ver
and succulent, of rapid growth, tending to e
into neighbouring cavities, to fungate throug
skin, to affect the lymphatic glands, and to b
disseminated.

As they increase in size, they expand the wall
antrum on all sides. Thus, they thrust inward
outer wall of the nostril, and obstruct respiration
push up the floor of the orbit and cause protrus
the eyeball; backwards, they extend to the pha
and downwards, they either cause the hard pal
bulge, or else make their way between the two l
of compact tissue of the alveolar process, and,
loosening one or more of the teeth, fungate thr
the gums. Any tumour growing within the an
tends to distend the cavity in this way, but mali
tumours do so in a more typical manner than d
innocent growths. Glandular affection is not cor
in cases of sarcoma of the antrum, but does some
occur.

In addition to the myeloid tumours, fibro-
mata occasionally develop within the lower jaw.
These are sometimes hard, and fibrous on se
and contain within their substance numerous os
granules. They are apparently not very malig
and, when completely removed with the bone in v
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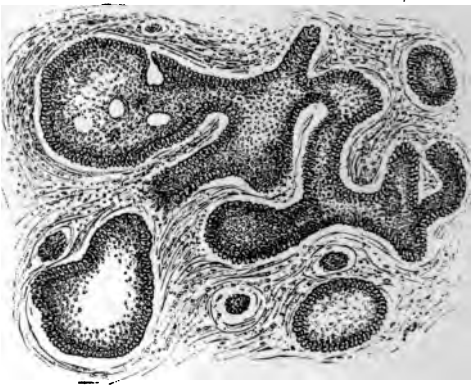

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swelling is situated, or else, if the latter has been already shed, that a permanent tooth is missing. Although the retained tooth is at first adherent to the sac-wall, it becomes detached after a time, and may be found loose in the cavity. Dentigerous cysts appear to be most common in young adults, but have been met with in middle age.

Diffused osseous growths.—The bony tumours which are found in the antrum are peculiar in this respect, namely, that instead of growing from some one definite portion of the antral wall, they are diffused over the whole area of the latter. There is thus no definite tumour, but rather a general thickening of the whole of the bone which encloses the antrum, and a consequent gradual obliteration of the antral cavity by the new bone thus formed. But although the increase of bone is mainly confined to the neighbourhood of the antrum, it extends after a time to the other portions of the superior maxilla, and may thus form a very considerable tumour. The growth of these osteomata is slow, and may extend over many years; their clinical course is entirely innocent; they are of rare occurrence, and are usually found in young people.

Cartilaginous tumours of the maxilla are extremely rare; as in many other bones, the growth of the cartilage is usually associated with that of sarcomatous elements.

Odontomata, or tumours of the teeth, may be either composed of true bone or of enamel. The latter never cause any symptoms, and are of little practical interest, but the exostoses of the fangs, as well as the tumours which cause the so-called "warty teeth," may be the cause of much trouble and pain, and may form very considerable growths in the jaw-bones. These warty teeth are subdivided into two varieties—the circumscribed and the diffuse dentinal odontomata. *In the former*, a portion of a single

tooth is alone occupied by a small outgrowth. In the latter, the whole tooth is misshapen and faultily developed, its place being taken by an irregular mass of dentine, enamel, and bone, whilst sometimes two teeth are fused. Tumours of this nature are very rare. The largest specimen hitherto described was as big as a turkey's egg, and another as large as a chestnut is on record. They grow within and expand the jaw-bone, and have hitherto been met with only in the inferior maxilla.

CHAPTER XXXVI.

DISEASES OF THE SPINE.

SPINAL CARIES.—ANGULAR CURVATURE.—POTT'S DISEASE.

Caries of the spine, or Pott's disease, is a strumous osteitis affecting the bodies of the vertebræ.

It occurs especially in scrofulous children, but is not limited to any age, and is frequently attributed to some injury. Any part of the spine may be affected, but the dorso-lumbar region is more often involved than any other.

The disease commences in most cases as caries of the cancellous tissue of the anterior part of the vertebral bodies immediately beneath the compact bone to which the intervertebral discs are attached. In other cases the disease appears to be primary in the intervertebral discs, and only secondarily extends to the bodies.

Sometimes the destructive process commences in a single vertebra, and extends from this as from a centre to the neighbouring vertebræ. In other specimens it is evident that the caries has been originally diffuse, and has implicated many parts of the spine at one and the same time.

The changes that occur in strumous osteitis have already been described in detail. In the spine the process commences as a very insidious form of inflammation, accompanied by a growth of lowly organized granulation tissue in the cancellous spaces. This is followed by rarefaction and absorption of the can-

cellous bone, and by caseation or calcareous degeneration of the inflammatory products. As in all cases of strumous osteitis, tubercle is to be found on microscopical examination. By a continuance of this process, the body of the diseased vertebra is gradually destroyed, and the granulations extend into and destroy the intervertebral discs, and then involve the neighbouring vertebræ. It is to this gradual destruction of the bone that one of the most notable symptoms of spinal caries is due, namely, **angular curvature.** The weight of the head, shoulders, and trunk is transmitted to the lower extremities through the vertebral bodies, and it is evident that, if these soften and crumble away, the yielding and pulpy bones will be crushed together by the superimposed weight, so that as fast as the bone is absorbed by the granulation tissue just so fast are the diseased bodies and discs compressed. But the spinous, transverse, and articular processes are not destroyed; and if the anterior part of the spinal column, which is formed by the bodies, is shortened, whilst the posterior part, formed by the processes, is intact, it is evident that, as the bodies are compressed, the spinous processes must project backwards. In this way the angular curve is produced, the apex of the angle being formed by the spine of that vertebra which is nearest the centre of the destructive process.

The further course of a case of Pott's disease depends much on the circumstances in which the patient is placed. When he is kept at rest and under good hygienic conditions, the caries may stop, the inflammatory exudation may cease, the caseation of the granulation tissue may give way to organization and formation of fibrous tissue, and the diseased vertebræ may be fixed to one another by fibrous adhesions or by bony anchylosis, any angular curve which has been produced being thus rendered permanent. This *reparative* process is not limited to the vertebral *bodies,* b[illegible]ed by changes in the intervertebral

culations, which result in fixation of these joints adhesions, and in the formation in some cases of y plates uniting the transverse processes.

In a large majority of cases no such favourable mination as that above described takes place, and constant rubbing of the diseased bones causes the gression and extension he destructive process. In such patients the nulation tissue breaks wn into ill-formed ca- ous pus, which escapes rough apertures at the nt or sides of the ca- ous vertebra, and in ny cases strips the an- rior common ligament m its attachment for considerable extent. ry frequently the liga- nt effectually resists e pressure of the pus, d causes it to make its y laterally to the soft sues at the sides of the eased vertebra. From situation it may either k backwards with posterior branches of intercostal or lumbar ries and nerves, forming a dorsal or lumbar abscess, may pass forwards into the tissues on the front sides of the spine.

FIG. 60.

Spinal Caries. One intervertebral disc has been destroyed with the greater part of the vertebral bodies on either side of it. The anterior common ligament is partially separated. The spine presents a slight angular curve.

f such an abscess forms in the cervical region, it point behind the pharynx, may pass laterally veen the muscles of the neck, may track downds and enter the axilla with the axillary vessels nerves, or in rare cases extend into the mediastina. When the lower dorsal vertebræ are involved, the

pus often tracks downwards, passes beneath the ligamentum arcuatum internum, and thus enters the sheath of the psoas muscle; or, in cases where the lumbar vertebræ are themselves diseased, the pus, escaping at the lateral margins of the bodies, is discharged directly into the fibres of the psoas which are attached to this part of the spine. In either case, the pus collects slowly in, and gradually tracks along, the muscle until it passes with it from the abdomen to the inner side of the thigh.

When the pus misses the sheath of the psoas, it either enters that of the iliacus muscle, and points above Poupart's ligament, or else it passes down into the pelvis. From the pelvis it may escape by passing through the sacro-sciatic notch and pointing as a gluteal abscess, by tracking along the rectum into the ischio-rectal fossæ, or by bursting into one of the hollow viscera. Wherever the abscesses are situated, they are always at first chronic, and extend very slowly. In some rare cases, where treatment is rigidly carried out, the fluid portions of such pus may be absorbed, and the more solid parts may remain as a gritty or cheesy mass for many years. More commonly, after reaching a cutaneous surface, the abscess bursts, and, becoming contaminated by exposure to the air, a more acute inflammation of the abscess-sac ensues, pus is secreted more rapidly and in larger quantities, and suppurative or hectic fever, amyloid disease, or general tuberculosis brings about a fatal termination. In the larger number of discharging abscesses, small crumbs of dead bone may be found, and in many cases sequestra of considerable size are formed, which, being unable to escape from the seat of their formation, keep up a constant discharge of pus, and prevent sinuses from healing.

The spinal cord in most cases of angular curvature escapes compression for the reason that, the inter-articular joints being intact, the curvature does

not cause a narrowing of the spinal canal. This, however, is not always the case, and in many specimens the calibre of the canal is distinctly diminished by a backward displacement of the softened bone at the seat of the greatest curvature. Such a narrowing, fortunately, does not necessarily imply interference with the functions of the spinal cord, and it is certain that the latter can indeed be considerably compressed

FIG. 61.

A Spine, showing an acute angular curve, with narrowing of the spinal canal and flattening of the cord.

without any symptoms arising, provided that the flattening is gradual, and not the result of sudden displacement. In some cases, nevertheless, **paraplegia** does occur, and appears to be caused by an extension of inflammation to the meninges, with resulting pachymeningitis, or by the exudation of inflammatory products into the spinal canal. In the large majority of cases, moreover, the paraplegia is transient, and

although in some it is rendered permanent by reason of structural changes in the cord itself, yet in most instances a good prognosis may be given if the patient is otherwise not too ill, and is placed under appropriate treatment. It should be added that, in cases of disease of the cervical spine, the danger of pressure on the spinal cord by displacement of the diseased vertebræ is much greater than in dorsal and lumbar caries, where the parts are steadied by the ribs, by the large trunk-muscles, and by the greater size of the opposed vertebral bodies.

LATERAL CURVATURE.

Lateral curvature of the spine is commonly the result of muscular weakness and overwork in growing girls and boys about the age of puberty, at a time when great demands are made on the strength. It is also caused by anything which renders one leg shorter than the other—*e.g.*, old hip disease—the spine being obliged to curve in order to allow the foot to reach the ground. Some of the very worst cases result from an altogether different cause, namely, the falling in of the ribs which commonly follows empyæma.

So soon as the muscles lose tone and cease to support the spinal column, the ligaments yield and allow the curvature to commence. The direction of the curve is to a great extent determined by the habits or occupation of the patient, but the most common primary deviation is seen in the upper dorsal region with the convexity to the right.

As soon, however, as the upper part of the spine curves to the right, the lumbar region develops a compensatory curve to the left, this being necessary in order to allow the patient to maintain the upright posture. At the same time that the lateral curvature occurs, the vertebræ also rotate, the rotation always being in one direction. The bodies are turned towards

the convexity of the curve and the spines towards the concavity, so that the transverse processes towards the convexity are thus thrust backwards and made to project. The ribs necessarily follow the rotatory movements of the spine, and the shape of the thorax is altered in proportion to their displacement; the shoulder is thrust up, and the hip on the same side raised. In cases of long standing, the bodies of the vertebræ and the intervertebral discs become in time compressed on the side of the concavity.

CHAPTER XXXVII.

DISEASES OF JOINTS.

SIMPLE OR SEROUS SYNOVITIS.

A SIMPLE synovitis is an inflammation of the synovial membrane which is not dependent upon any constitutional disease or upon the introduction of septic material from a wound or neighbouring inflammation. This is one of the commonest troubles to which joints are liable, and affects particularly those articulations which are the most freely movable and the most exposed. The usual causes of simple synovitis are injury and exposure to cold or wet.

Acute synovitis.—The changes in the synovial membrane do not differ from those met with in inflammations of other soft tissues. At first there is intense hyperæmia, followed shortly by swelling, and exudation of fluid both into the membrane itself and into the articular cavity. The swelling is greatest in the situation of the normal folds; *e.g.*, in the ligamenta mucosa and alaria of the knee, which, by their increase in bulk, overlap the cartilages, and contrast strongly with the pearly-white colour of the latter.

Microscopically examined, there is seen to be much cell exudation into the perivascular spaces, with swelling and softening of the connective tissue by the excess of fluid in which it is soaked. The dilated capillaries occasionally give way, and thus cause minute extravasations of blood. The leucocytes escape into the substance of the membrane itself, and also pene-

tween the endothelial cells and reach the cavity. The endothelial cells appear to with unusual rapidity, and are liable to be nto the joint in considerable numbers.

ges in the synovial fluid.—In the early f an acute synovitis, the synovial fluid is ıcreased in quantity, but, as the inflammation ɜs, the normal secretion is mingled with serum ng proportions, and afterwards with the ·ming elements of the blood, and with red and puscles. At first the fluid is clear, but later on ıes cloudy, opalescent, or blood-stained. In ere the original injury has been severe, there ı considerable extravasations of blood into the cavity. In most cases the blood does not some time, probably on account of its ad- with the serum and synovia, as well as of the smooth endothelial lining with which ɔntact.

ıimple acute synovitis undergoes resolution, ation of cells ceases, the vascularity subsides, ed fluid is absorbed, and the membrane and ɜtion again present a natural appearance. here is much extravasated blood, resolution ılly greatly prolonged.

acute and chronic synovitis.—If a joint the seat of an acute synovitis be not kept at a sufficient length of time, the inflammatory is liable to pass into a sub-acute or chronic ıd the absorption of fluid from the articular ases. In other cases, the inflammation, from ınning, is of but slight intensity.

s form of synovitis there is little hyperæmia, n a good deal of swelling, and where the ıtion is of long standing the membrane itself to be much thickened by the formation of issue.

uid in the joint is generally greatly in excess is natural, and consists chiefly of serum. It

is usually quite clear, but may contain small shreds of fibrin, or the melon-seed bodies which are more commonly seen in bursæ. The long-continued distension of the joint is liable to result in the stretching and weakening of its capsule and ligaments. The terms "hydrarthrosis" and "hydrops articuli" have been applied to the more chronic forms of synovitis with effusion.

ACUTE SUPPURATIVE ARTHRITIS.

Acute suppurative arthritis is a general septic inflammation of all the structures which enter into the formation of a joint. It may be produced in one of the following ways:—

1. By a wound which opens the articular cavity.

2. By extension of inflammation from the articular bone, especially by tracking of pus in cases of acute periostitis, or by the rupture of an abscess in the bone.

3. By extension of suppuration from the soft tissues. This is rare in cases of simple suppuration, but may result from sloughing of the tissues over a joint after an injury, from phlegmonous erysipelas, or from extension of suppuration from a bursa which communicates with the articulation—*e.g.*, the bursa beneath the psoas.

4. As a complication of various forms of blood-poisoning, especially pyæmia, puerperal fever, and more rarely typhoid fever, scarlatina, gonorrhœa, &c.

The synovial membrane is the first of the articular structures which shows signs of inflammation. It becomes at first bright red and swollen, and in a very short time it loses its polished appearance, and is covered with shreds of adherent fibrin. If the latter are peeled off, the synovial surface is found to be rough and velvety, like granulation tissue. The synovial fluid is increased in quantity, soon becomes blood-stained and opalescent, and very shortly is mingled with pus which has been secreted by the *inflamed* synovial surface.

Within a day or two the inflammatory process extends from the synovial membrane to the cartilages, and the latter lose their pearly-white colour, are permeated by new blood-vessels, and ulcerate in patches, or necrose and are cast off in shreds.

The ligaments share in the general suppuration; their dense structure is split up by infiltration of serum and pus, and they become ragged and shreddy, yield, and allow displacement of the articular surfaces. The bones are not spared. The cartilages being destroyed, osteitis ensues, and the usually smooth layer of articular bone becomes rough and carious. The peri-articular tissues share in the general suppuration, and abscesses form around the joint. In many cases the suppuration in the tissues is the result of the yielding of the softened and distended capsule, which thus allows the sudden escape of its contents. This is a fact of much clinical importance, for, when the pus escapes from the joint, the swelling and pain in the latter often partially subside, and, unless the surgeon be on the watch for it, he may overlook the pus outside the articulation. In cases of acute suppuration of the knee, collections of pus may extend amongst the muscles of the thigh almost as high as the hip-joint.

The microscopical appearances in suppurative arthritis do not differ from those ordinarily met with in acute inflammations of bone and soft tissues in other parts of the body, and require no special description.

Acute suppurative arthritis is accompanied by much redness and swelling of the inflamed joints, by great pain, and severe constitutional disturbance. If not properly treated, it may terminate fatally, and in many cases, even when by free incisions the pus has been satisfactorily evacuated, amputation has subsequently to be resorted to on account of the exhaustion which follows the discharge of large quantities of pus, and the accompanying suppurative fever.

If recovery ensues, the joint is usually left in a state of bony anchylosis, and, this being the case, it is evidently of the utmost importance to see that the limb is kept in as good a position as possible. In such cases, after the pus has been evacuated and the acuteness of the inflammation has subsided, the suppuration gradually ceases. The cells which have been exuded into the substance of the synovial membrane, cartilage, bone, &c., are gradually developed into fibrous tissue, in which, where it is in contact with osseous tissue, bone salts are subsequently deposited. The hyperæmia subsides; the fibrous tissue, which is not ossified, shrinks; the cavity of the joint is obliterated; and the articulation, as such, ceases to exist.

In favourable cases, and especially in children, when the pus has been early evacuated, a more or less movable articulation may remain, though, at best, such a joint is permanently weak, and stiffer than natural.

ACUTE ARTHRITIS OF INFANTS—ACUTE EPIPHYSITIS.

These names are applied to cases of acute suppurative arthritis occurring in infants and children, and resulting from inflammation of the articular bone. Attention has been specially directed to this subject by Mr. T. Smith.

The patients who are the subjects of this form of disease are seldom more than a year or eighteen months old. The joints most commonly affected are the hip, knee, shoulder, ankle, and elbow.

The clinical course is rapid, and does not differ materially from that of acute suppurative arthritis due to injury. In some cases there is a history of a blow or other injury; in others, none can be obtained.

The disease appears to commence as an acute inflammation of the most recently formed bone around the centres of ossification and commonly results in

and the formation of a minute sequestrum. this, pus is formed, and subsequently makes into the neighbouring articular cavity, the by which the pus escapes into the joint from hysis being often so minute that the real cause arthritis is liable to be overlooked unless a is made of the articular bone. This escape of is followed by acute arthritis and the formation rticular abscesses.

cases terminate fatally, but, if an early exit to the pus, the patient ly recovers. In some s the joint, in spite of eness of the inflamma- fers comparatively little nt injury. In others, re unfortunately the mmon, the growth of e is seriously affected, articular extremity nently deformed. In es the joint is liable to emely loose and flail- d, in the case of the xtremity, is unable to adequately the weight ody.

FIG. 62.

Section of the Upper Part of a Tibia, showing a sequestrum of cancellous bone. Necrosis resulted from acute epiphysitis.

e epiphysitis is not, , limited to infants, s of a precisely similar are not infrequently h in older children and g adults, and run a very similar course. The f the necrosis in these cases is nevertheless liable ch greater than in infants, and sequestra of con- e size may be formed. The tendency of the extend into the neighbouring joint and to ute arthritis is unfortunately as great in these in the younger patients, and the prospects of

recovery with a movable articulation are by no means so good.

ARTHRITIS FOLLOWING THE EXANTHEMATA.

Of all the exanthemata, scarlatina is more frequently followed by inflammation of the joints than is any other. In cases otherwise uncomplicated there is frequently a sub-acute synovitis of several articulations, resembling closely in its clinical characters the synovitis of acute rheumatism, and running a similar course. In those cases of scarlatina, however, which are complicated by parotid buboes, sloughing of the tonsils, &c., there may be a genuine pyæmic arthritis, which runs the course typical of such a disease. Mumps, dysentery, and measles may be followed by similar inflammation of the joints. Typhoid fever and, more rarely, small-pox may also be followed by disease of the articulations.

In many cases, and especially after typhoid, one joint alone is attacked, and of all joints the hip is that most frequently implicated. The character of the inflammation differs in different cases. In some there is a simple synovitis; in others, a more general arthritis, terminating in anchylosis more or less complete; in others, again, there is acute suppurative arthritis. The hip-joint is liable to be affected in a somewhat peculiar manner, for in many of these cases there is a very rapid effusion into the synovial cavity, accompanied by softening and stretching of the ligaments, and followed by spontaneous dislocation of the femur on to the dorsum ilii. All this may occur without the formation of any pus.

URETHRAL ARTHRITIS (GONORRHŒAL RHEUMATISM).

The term urethral arthritis is applied to cases of inflammation of joints following urethritis, and is preferable to the older one of "gonorrhœal rheu-

matism," for it may complicate cases which are not of venereal origin, and, although more common in males, is seen in some cases of simple leucorrhœa in women. Certain individuals seem especially predisposed to this form of arthritis, which appears to attack by preference those who are of a gouty or rheumatic diathesis. The real nature of the affection is still unsettled, but by most writers it is considered to be the result of absorption of septic material from the urethra. Others look upon the disease as of neurotic origin, and think that it is excited reflexly. In urethral arthritis one large joint—and that most commonly the knee—is usually affected, but no joint is altogether exempt, and, the fasciæ in the sole of the foot may be implicated, and may, by their yielding, lead to the production of flat foot.

The disease appears to be essentially an inflammation of the synovial membrane and ligamentous structures, and is very liable to be extremely chronic, to recur occasionally, and to terminate in fibrous anchylosis. More rarely, suppurative arthritis supervenes, and runs a course such as has been already described.

PYÆMIC ARTHRITIS.

In most cases of pyæmia one or more joints become inflamed. In many cases the inflammation is limited to the synovial membrane, and the joint is quickly filled with a mixture of synovia, serum, and thin, yellow, oily pus. In several such instances in which I have made post-mortem examinations, the joint, after having been washed out, presented no signs of inflammation, save a slight swelling of the synovial membrane, and no signs of ulceration of cartilages or bones could be seen. In cases such as these the effusion may be absorbed, and the joint may then either return to its natural condition or may be partially anchylosed by the formation of fibrous *adhesions. I have* on several occasions seen joints

become quite stiff after pyæmia without the occurrence of any suppuration. This is not, however, always the case, for sometimes the pus is produced in greater quantities, the inflammation spreads to the cartilages, bones, and ligaments, and a general suppurative arthritis ensues.

In puerperal fever, the joints may be affected as in pyæmia.

GOUT.

Gout is a constitutional disease characterized by inflammation of the joints, with deposit of urate of soda in the articular structures. The general pathology of gout is beyond the scope of the present work, and the changes in the articulations cannot be described at length.

The patients most subject to gout are those of the uric-acid diathesis, and are commonly past middle age. The joint most often affected is the first metatarso-phalangeal, probably for the reason that it is more frequently than any other damaged by pressure of ill-fitting boots, &c. No joint is exempt from attack. Gout is commonly said to be a disease of the rich and not of the poor, but this is certainly incorrect, and in a very considerable proportion of post-mortem examinations of hospital patients over fifty years of age I have found urate of soda in one or more articulations.

The affected joints are liable to attacks of acute inflammation, but in many cases a joint appears to become the seat of gouty deposit without any history of an acute arthritis.

The morbid changes are chiefly as follows:—In any acute attack the synovial membrane presents the appearances common to all cases of simple synovitis, and the synovial fluid is similarly changed in amount and character.

The cartilages are inflamed, their matrix fibrillates, *and* [illegible] cells multiply. In the fibrillated cartilage,

and on its surface, a white deposit of urate of soda ensues, and, in subsequent attacks, the cartilages become more and more fibrillated and worn away, and the urate of soda increases in quantity.

When the bones are exposed, they, in their turn, become the seat of gouty deposit, and not only they, but the ligaments, synovial membrane, peri-articular connective tissues, and bursæ are similarly affected.

It is commonly stated that the urate of soda is simply deposited on cartilages which are otherwise normal, but my own experience is that this is not the case, and that wherever there is urate of soda there the cartilage is generally fibrillated and eroded. It appears probable that some at least of the urate of soda is formed by disintegration of the cartilage itself, and that it is not simply deposited independently of antecedent changes in the cartilaginous matrix. In very many cases, joints which are the seat of gouty arthritis present many of the changes which characterize osteo-arthritis. When the deposit of urate of soda is considerable, it may extend into the neighbouring tendon-sheaths, and, still increasing, may cause ulceration of the superjacent skin. In such cases, the protruding mass is called a "chalk stone;" these are more common in the fingers and ears than elsewhere.

RHEUMATISM.

The subject of acute rheumatism is one of medical rather than of surgical import, and the changes in the joints alone will be considered here.

In many cases there is nothing more to be seen on examination than in simple serous synovitis, but in acute rheumatism there is a definite tendency for the inflammation to extend to the sub-synovial and peri-articular tissues and for the synovial secretion to be more fibrinous, and consequently more shreddy than in simple synovitis. In severe cases the cartilages acquire a bluish or opalescent tint, and may

be distinctly swollen; in such instances, microscopical examination shows cell proliferation and exudation, and in a few cases the surface becomes fibrillated or eroded. The ligaments appear to be comparatively frequently implicated, but the inflammation rarely extends to the bones.

The ordinary duration of the synovitis in a simple case, in any individual joint, varies from about three days to a fortnight, but in more severe cases, where the deeper structures are implicated, the inflammation often drifts into a sub-acute or chronic stage. As a rule, most patients recover without any permanent joint lesion, but it will easily be understood that, where the ligaments and peri-articular structures have been involved in a plastic inflammation, permanent stiffness or complete fibrous anchylosis may result. This does not often occur in more than one joint. In rare instances even suppuration may ensue.

The term **chronic rheumatism** has been very vaguely applied. It is better not to use it as synonymous with osteo-arthritis, but to limit it to cases in which, after one or more attacks of acute rheumatism, a chronic synovitis, with thickening of the ligaments and peri-articular structures by fibrous adhesions, supervenes. It may affect one or more joints, and frequently terminates in fibrous anchylosis.

CHAPTER XXXVIII.

DISEASES OF JOINTS—(*continued*).

OSTEO-ARTHRITIS.

OSTEO-ARTHRITIS is a form of chronic joint disease characterized by peculiar degenerative changes in the articular structures, which do not tend to terminate in either anchylosis or suppuration. Other common names for the same disease are "rheumatic gout," "rheumatoid arthritis," "chronic rheumatic arthritis," "arthritis deformans," and there are many more.

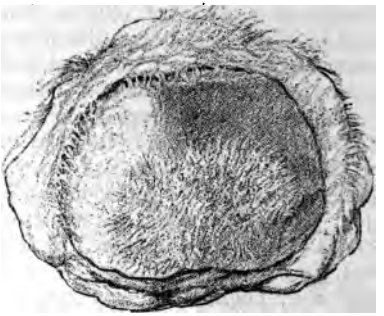
The morbid anatomy of osteo-arthritis is very striking, and in well-marked instances the pathological changes cannot be mistaken for those of any other disease.

The disease may begin either in the synovial membrane or in the cartilage, and, judging by my own experience, which has been derived from an examination of many joints in the post-mortem room, I should say that changes in the cartilage almost always precede those in the synovial membrane.

Changes in the cartilage.—The first thing that is noticed is a slight roughening of the normally smooth cartilage, which, when subjected to a gentle stream of water, is seen to be broken up into delicate fibrils, arranged with their long axes at right angles to the articular surface, and resembling the pile of coarse velvet. This change is always most noticeable at those parts which are subject to the *greatest pressure or friction*, whilst at the margins

the cartilage hypertrophies, and forms irregular nodular outgrowths, or "**ecchondroses.**" These outgrowths, at first cartilaginous, soon become bony in their deeper parts; the ossification extends through their whole thickness, and the "nodular osteophyte" thus produced is fixed more or less firmly to the subjacent bone, the articular borders of which are thus rendered prominent or "lipped." Sometimes these nodular masses are broken off, and form loose bodies in the joint, or in the substance of the synovial membrane itself.

FIG. 63.



A Patella from a case of Osteo-arthritis, showing fibrillation of the cartilage.

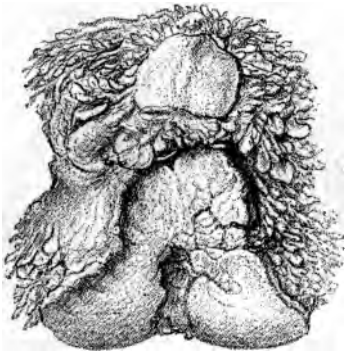
As the disease progresses, the fibrillated and degenerate cartilage, no longer able to resist the attrition to which it is subjected by the movements of the articulation, is slowly worn away in patches, and the subjacent bone is exposed.

A microscopical examination of the cartilage in this stage throws much light on the progress of the disease. The normal hyaline matrix is broken up into fibres, in the midst of which the cartilage cells are found to be arranged in vertical columns whose long axes are at right angles to the articular surface. The cells

roliferate and distend their capsules until they burst, rith the result that the cells nearest the surface are ast loose into the synovial cavity. In this way he surface of the cartilage is broken up, and the ibrillated matrix between the rows of cells remains to orm the longitudinal striæ and tufts which give the elvety appearance already described.

At the margins, where the ecchondroses are formed, he same proliferation of cells and fibrillation of the natrix ensue, and it has been suggested by Cornil

FIG. 64.



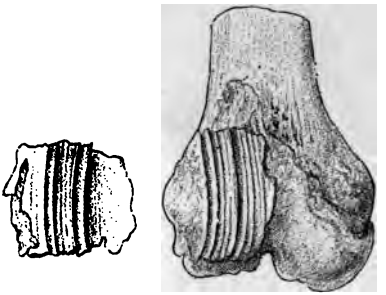
Femur, Patella, and Synovial Membrane from a case of Osteo-arthritis. The articular surface of the femur is deformed by the formation of large ecchondroses, and the synovial membrane is covered by hypertrophied synovial fringes.

nd Ranvier that the heaping up of new cartilage in his situation is to be explained by the fact that the dge of the cartilage is covered by a prolongation f the synovial membrane; the cells, consequently, nstead of escaping into the synovial cavity, are re-ained in the sub-synovial tissue, and by their constant nultiplication produce the cartilaginous outgrowths. n some cases these ecchondroses protrude the synovial nembrane in front of them, and at length project

through it, so as to become intra-articular. In ot instances they grow laterally, and do not encro upon the joint.

The synovial membrane in the early stage the disease shows little change, but after a t becomes increased in vascularity, as well as thic and tougher. In the later stages its fringes incre in size, their villous tufts hypertrophy and subdivi and gradually the whole membrane assumes a sha or villous appearance. These enlarged villi chiefly fibrous in structure, but often contain a li

FIG. 65.



Femur and Patella from a case of Osteo-arthritis. Both bones are much deformed, and marked by deep grooves.

fat. In other cases cartilage is developed in them and more rarely they become calcified or ossified As they increase in size they get more pedunculated and occasionally are completely detached, thus formin one of the varieties of "loose bodies in joints."

The synovial fluid in the early stages of the disease i commonly increased, frequently to a very great extent it is usually more cloudy and tenacious than is natural As the arthritis advances, the secretion is liable t diminish, and to become still more thick and viscid.

The changes in the bones are very characteristi The cartilage being worn away, the articular bone

exposed, and, in consequence of the friction to which it is subjected, becomes smooth and polished. The subjacent cancellous tissue also undergoes rarefaction and atrophy, with the result that the degenerate osseous tissue is quickly worn away in the movements of the diseased joint. The surface bone, by reason of the attrition, becomes smooth and polished, ivory-like or eburnated, and is usually not worn evenly, but in grooves. These are to be attributed to the rubbing of the opposed bone-lamellæ, which are arranged at right angles to the articular surface, and tend to scrape the opposing bone as might the teeth of a comb. As a rule, the cancellous bone is not exposed by the atrophic process, for as the surface layer of smooth bone is worn away it is as constantly reproduced. This, however, is not always the case, and sometimes the enlarged Haversian canals may be seen opening on to the articular surface, and giving the bone a "worm-eaten" appearance. In some articulations there is also a formation of very dense and porcelain-like bone, which is met with in no other form of joint disease. It is developed where there has been much friction, and, on account of its white appearance, is called "porcellanous."

FIG. 66.

The Upper Part of a Femur from a case of Osteo-arthritis. The cartilage of the head has been destroyed, and the articular bone is smooth, polished, and worn down. Several nodular osteophytes have developed on the neck.

But whilst these changes are in progress when the bone is exposed to friction, other changes ensue at the articular margins. Here, as has already been described, the nodular osteophytes are developed from the cartilaginous *outgrowths,* and by a continuation of the

wearing away of articular bone, and the production of these bony "lips," the shape of the articulating surfaces becomes profoundly changed. Thus, in the hip, the head of the femur is worn away and flattened, whilst from the margins of the articular cartilage nodular growths arise. In the course of time the whole head may be absorbed, and the articular surface may be formed by the polished stump of the neck. In the acetabulum, the floor is polished and smooth, and the margins worn away and overgrown by new bone, so that the shape and even the position of the cavity are quite altered.

Osteophytes are also, but more rarely, developed at the points of insertion of muscles, or in the capsule close to its attachment to the bone.

The ligaments share in the general destruction, and, like the other tissues, seem rather to degenerate and wear away than to be destroyed by any active process. If examined when fresh, their texture is seen to be more loose than natural, and their surface presents a ragged or frayed appearance. On account of their softened condition, they tend to allow the articulating surfaces to be displaced and loosened.

In many cases the **tissues outside** the affected joints suffer. Thus, the neighbouring muscles waste, the subcutaneous tissues become œdematous, and the skin is often shiny and smooth. Tendons also in the near neighbourhood fibrillate and wear away, just as do the intra-articular ligaments. This change is best seen in the shoulder-joint, where that part of the long tendon of the biceps which lies within the capsule is usually found either thinned and flattened or else entirely absorbed.

The patients who are the subjects of osteo-arthritis are usually over middle-age, but the young are not always spared. Sometimes only one large joint, and that by preference the hip or the shoulder, is affected; in other cases several articulations are

ıttacked, and, when the knee is implicated, the disease s commonly symmetrical. In the case of the hands, ıll the finger-joints are liable to be diseased. However ong osteo-arthritis lasts, it never causes true anchy- osis, except when the vertebræ are involved. It requently results in great and serious impairment of he mobility of the joints, but this is explained by the ılterations in the shape of the articular surfaces, by the destruction of the cartilage, and by the thicken- ing of the synovial membrane. In other cases, undue mobility and laxity result from destruction of liga- ments and wearing down of the articular bone.

Osteo-arthritis is usually very chronic and slow in its progress, but is occasionally of tolerably acute onset, and progresses rapidly. When occurring in early life, it is more liable to attack many joints than when it commences in old age.

Osteo-arthritis appears to follow attacks of acute rheumatism in a very small percentage of all cases, and certainly is most common in patients of a rheumatic or gouty descent. In many instances it is apparently to be attributed to frequent exposure to cold and wet, as well as to insufficient nourishment. In the case of the hip, it is certainly sometimes induced by an injury, especially by a fall on the trochanter. This is a fact of much clinical importance, and affords a ready explanation for those cases where shortening and eversion of the thigh follow within a few months of a fall on the hip. When the result of injury, osteo-arthritis appears often to progress with unusual rapidity, and the deformity it causes may easily be mistaken for that which results from an impacted intracapsular fracture.

The true pathology of osteo-arthritis is still obscure. In its nature it seems to be more degenerative than inflammatory, but whether it is the result of an inherited or acquired diathesis, whether an expression of gout or rheumatism, or whether, as is supposed

by some, of neurotic origin, is at present a matter of doubt.

CHARCOT'S DISEASE—TABETIC ARTHROPATHY.

Charcot's disease, as it is met with in this country, is a form of arthritis, allied to osteo-arthritis, which is developed in connection with tabes dorsalis. It is met with in but a small percentage of cases of tabes, and often commences when the tabetic symptoms are but little marked, or even unnoticed by the patient; very frequently it occurs before there is any evidence of ataxic gait. As described by Charcot, the disease is usually of very sudden onset, the affected articulation becoming distended with effusion within twenty-four or thirty-six hours, without any apparent cause. This swelling of the joint is often accompanied by swelling of the neighbouring soft tissues, which do not, however, pit on pressure to any extent. In some instances the effused fluid is absorbed, and the joint returns to its natural condition; but in others, and these unfortunately are the more common, the effusion is but the commencement of a series of changes, which rapidly terminate in the destruction of the articulation. Within a few weeks or months from the first attack the patient notices that the joint gets weaker and gives way under him, and, in a very short time, undue mobility, with the production of a "flail joint," movable in all directions, or else actual dislocation ensues. One of the most noticeable of the clinical features is the entire absence of pain throughout the progress of the case.

If such a joint be examined, it will be found that the morbid appearances are very similar to those met with in osteo-arthritis. But just as Charcot's disease differs in its clinical course from osteo-arthritis in the rapidity of the destruction and the exceeding mobility, or even dislocation, of the articulation, so *in its anatomical* aspects it differs in the extent of

destructive changes rather than in their cha-
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e synovial membrane and its secretion show the
appearances which have been described as occur-
in osteo-arthritis, but the synovial fluid is almost
's greatly increased in quantity.
e cartilages fibrillate and wear away, and from

FIG. 67.

e-joint from a case of Char-
isease, showing the exces-
aring away of the bones
ne displacement of the
ır surfaces.

FIG. 68.

Another View of the Bones depicted in the Last Figure, showing the complete wearing away of one of the femoral condyles.

margins spring ecchondroses. The ligaments also
ate, stretch, and waste.
e most characteristic changes are found in the
. These, in typical cases, are worn down to
xtent never seen in osteo-arthritis, and are
ver often simply worn down without any new
being produced, as is common in the latter
e. In typical cases the whole of the head of
mur or humerus, the condyles of the femur or

the head of the tibia, are ground down and destroyed as if they had been rubbed away by a grindstone or a file. It is this extensive destruction of bone, even more than the wearing away of the ligaments, which must be held accountable for the dislocations and undue mobility above mentioned.

It is evident that bones which wear away in this manner must be in a state of advanced degeneration, and to such an extent are they sometimes degenerated that spontaneous fracture ensues, a complication which never occurs in simple osteo-arthritis.

From the above description it would appear that Charcot's disease is justly separable from osteo-arthritis, and that typical specimens of the one can be easily recognized and differentiated from those of the other. It would, however, be a grave error to suppose that this is always so, for both clinically and pathologically numerous connecting links may be found, and I have seen tabetic patients in whom the joint disease has lasted for several years, and whose articulations after death were not to be distinguished from those of osteo-arthritis.

There has been much discussion as to the true nature of Charcot's disease, but, although the question is yet far from settled, the general opinion is that it is directly dependent upon degeneration of either the spinal cord or of the peripheral nerves, for the latter have been shown to be affected in cases of tabes. If this be true, the joint affection must be classed as a neurosis, and thus becomes strictly comparable with the perforating ulcers of the foot, which are also common in patients with sclerosis of the posterior columns of the cord. Some surgeons, however, look upon Charcot's disease as identical with osteo-arthritis, and consider that any differences are explained by the fact that the disease occurs in a patient affected by tabes, whilst others consider that the disease of the spinal cord and of the joints may each be the result of some common cause.

CHAPTER XXXIX.

DISEASES OF JOINTS—(*continued*).

LOOSE BODIES IN JOINTS.

THE loose bodies found in joints vary both in structure and origin. They may occur in articulations otherwise healthy, or may complicate osteo-arthritis and chronic synovitis.

Loose bodies may be formed in the following ways:—

First, as the result of an injury, a portion of synovial membrane sometimes becomes thickened and indurated. It is probable that this condition originates in a rent or tear of the membrane, which is subsequently pinched and dragged upon in the movements of the joint, and is kept in a state of chronic inflammation. Bodies of this nature consist of fibrous tissue, fat, and inflammatory products. They are attached by a pedicle, which tends to become longer and thinner the longer the growth exists.

FIG. 69.

A Thickened Portion of Synovial Membrane, which formed a loose body in the knee-joint.

Secondly, in osteo-arthritis, as already described, the synovial membrane is liable to become covered more or less thickly with pedunculated growths springing

from the normal fringes, and consisting of fibr tissue or cartilage. These bodies, although at fi

FIG. 70.

The Condyles of a Femur from a case of Osteo-arthritis, showing a nodular osteophyte merely attached by a slender pedicle of synovial membrane.

attached, may be separated and cast loose into th synovial cavity.

Thirdly, in osteo-arthritis the ecchondroses whic

FIG. 71.

Two Portions of Articular Cartilage, apparently from the Femoral Condyles. They were removed by operation, one from the right knee, the other from the left.

spring from the margins of the articular cartila and consist of cartilage and bone, may become tached, and either remain in the substance of t

synovial membrane itself or else become loose in its cavity.

Fourthly, in some cases portions of the articular cartilage are found as loose bodies. It is supposed that they may become separated either directly by the application of violence, or may exfoliate as the result of some impairment of their vitality by an injury.

Fifthly, in cases where there has been effusion of blood or of inflammatory exudation, masses of fibrin and blood-clot may remain in the synovial cavity.

Sixthly, blood may be effused into the substance of a synovial fringe, and may subsequently be organized into a hard fibrous lump.

Seventhly, in one case a loose body was found to have been formed around the point of a broken needle.

Some of these modes of formation of loose bodies are of great rarity, and it is quite certain that the large majority of specimens are derived in the manner described under the first three heads. In the absence of injury, it appears probable that osteo-arthritis must be held responsible for the larger number.

If a loose body is left in a joint, free to move about without restraint, it commonly sets up a chronic synovitis, and, through causing sudden wrenches of the articulation whilst in use, often brings on an attack of acute synovitis. The usefulness of the limb is sometimes seriously impaired.

Of all joints, the knee is the one in which loose bodies are most frequently found, but the hip, the shoulder, and the elbow are occasionally affected.

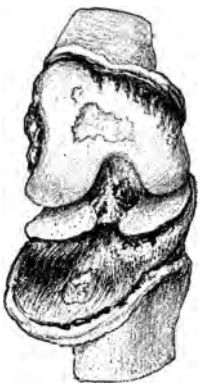
Internal derangement.—The subject of internal derangement is one which may be briefly dealt with in connection with that of loose bodies in joints, for there is some similarity in the symptoms caused by these two affections. The term is applied to cases in which a joint, especially the knee, occasionally becomes suddenly locked or fixed so as to temporarily prevent all *movement. It is* now tolerably clear that this

condition is generally the result of an injury to the ligaments which fix the semilunar cartilages, resulting in their displacement when any strain is suddenly thrown upon the limb. Beyond the inconvenience of such attacks, and the synovitis which follows them, no ill results ensue.

JOINT DISEASE IN HÆMOPHILIA.

In the disease known as hæmophilia, or the hæmorrhagic diathesis, *i.e.*, in patients who are commonly known as "bleeders," the joints are liable to become temporarily swollen after slight injuries, and, after many such swellings, sometimes become stiff. Specimens of joints affected in this way are very rarely met with; but in two cases which occurred in St. Bartholomew's Hospital, in which death resulted from prolonged hæmorrhage following slight skin wounds, an opportunity was afforded of examining many of the articulations. These specimens were described by Dr. Wickham Legg at meetings of the Pathological Society in 1881 and 1885,* and allusions were made by him to two other cases which have been recorded.

FIG. 72.



Knee-joint from a "Bleeder." The synovial membrane is stained with blood, and a roughened spot in the outer condyle of the femur indicates the place where the patella was fixed by fibrous adhesions.

It would appear that the swellings of the joints are

* See vol. xxxiii. p. 412, and vol. xxxvi. p. 488.

the result of hemorrhages, and that, either from the irritation caused by the frequent presence of clot in the joint or from the constitutional condition of the patient, the cartilages and synovial membrane undergo further changes. The former fibrillate and break up on their free surfaces, and become lipped at their margins as in osteo-arthritis; whilst the synovial membrane remains more or less stained by blood, and thickened by fibrous tissue. In one of the joints in the museum of St. Bartholomew's Hospital—a knee—there had further been a tough fibrous adhesion formed between the under-surface of the patella and the condyle of the femur (see Fig. 72). The ligaments were not noticeably affected. The bones were healthy, and there was no appearance of ulceration of the cartilages, or of such pulpy swelling of the synovial membrane, as is usual in strumous disease. It is probable that similar conditions are common in the joints of bleeders, and would evidently satisfactorily account for the symptoms met with in such patients.

SYNOVIAL CYSTS IN CONNECTION WITH JOINTS.

The occurrence of large cysts containing synovial fluid in connection with joints was first noticed by Mr. Morrant Baker, and recorded by him in vols. xiii. and xxi. of the "St. Bartholomew's Hospital Reports." Since the publication of the first paper ten years have elapsed, and during that time many other cases have been observed, in several of which I have had opportunities of examining the joints after removal. Some of these have been described by Mr. D'Arcy Power in papers in the Pathological Society's "Transactions."*

From a consideration of the various recorded cases and dissected specimens, it seems safe to draw the following conclusions:—

First, a cyst may exist in connection with a joint

* Vol. xxxvi. p. 337, and vol. xxxvii.

which is itself perfectly healthy, but if the cyst inflame, as the result of injury or of surgical treatment, disease of the articulation may secondarily result.

Secondly, in cases of osteo-arthritis and of Charcot's disease, cysts may form, and it is probable that they are more common in connection with these affections than under any other circumstances.

Thirdly, synovial cysts may complicate strumous or tubercular disease of joints.

FIG. 73.

Posterior View of a Normal Ankle-joint injected with Gelatine, to show the numerous small protrusions of synovial membrane through the posterior ligament. (From a specimen in the museum of St. Thomas's Hospital.)

Synovial cysts appear to originate in some cases in the distension of a bursa which normally communicates with the joint, and it is evident that, where there is a direct continuity between the cavity of a joint and that of a bursa, any inflammatory condition may extend from the one to the other.

In other cases the cyst appears to be formed by a *hernial protrusion* of synovial membrane which has

ıed by inflammation and distended by fluid; other instances it appears that the fluid is ɜ tissues and not confined by any definite ıovial membrane having given way at some

73—which is a drawing of a specimen pre- Mr. Shattock—it is seen very plainly that normal joint there is a tendency to pro- small pouches membrane be- fibres of the ıd it is easy to l that such pro- ight readily in- ıse of softening nation or dis- excessive syno-

FIG. 74.

A Knee-joint with a Synovial Cyst. One piece of catheter has been passed from the articulation into the upper part of the cyst, and another piece along an extension of the cyst on the inner side of the calf.

ɜmed in one of may attain con- ze, and I have in connection nee which con- ıt of clear syno-

he most impor- es presented by is the distance e main swelling uated from the ı with which it ınected. I have st which was low the middle of the calf, and which did ɔ have any connection at all with the knee, er was freely movable, painless, not swollen, d could be pressed from the cyst into the vity. Yet a year and a half later, when ı of the thigh had to be performed for

destructive disease of the joint, I was able to find a narrow track leading from the cyst into the outer side of the knee. The specimen is figured in the accompanying drawing (see Fig. 74). It is evident that such pathological facts as these have a great clinical importance, for, if not recognized, synovial cysts may be mistaken for chronic abscesses, and laid open, with the serious risk of exciting acute arthritis. Synovial cysts may occur in connection with almost any joint, but they appear most frequently in connection with the knee, and, after it, with the hip, elbow, and shoulder.

CHAPTER XL.

DISEASES OF JOINTS—(*continued*).

SCROFULOUS OR TUBERCULAR DISEASE OF JOINTS.

THE general pathology of scrofula or struma has been discussed in an earlier part of this work, and the relation which it bears to tubercle has already been pointed out.

Scrofulous disease of joints displays in a most characteristic manner all the essential features of a typical strumous inflammation. The process is exceedingly chronic; is liable to extend from its original seat to neighbouring structures; is attended by little or no tendency to repair; the inflammatory products are very liable to caseate, and chronic abscesses are common.

Joint disease of this nature has been described by various surgeons under different names. Thus, in England the term "pulpy degeneration of the synovial membrane," originally employed by Brodie, has for long been in common use, whilst in Germany "tumor albus," or white swelling, has been employed to denote the usual absence of acute inflammatory symptoms.

The patients who are most liable to this form of arthritis are certainly young children from three to twelve years of age, and as puberty is approached, not only does strumous disease become less frequent, but the *tendency to repair* is also greater. It would,

however, be a grave error to suppose that adults are exempt, for there is no period of life, even up to extreme old age, in which tubercular arthritis may not occur.

The joints most often affected are the hip and the knee; after these the elbow, ankle, and shoulder. Disease of the wrist is not very common in young children, but is comparatively frequently seen in young adults. In some cases there is clear evidence that the arthritis has been started—as may any other strumous process—by an injury; but it is quite certain that this is not always the case, and I have seen scrofulous arthritis originate whilst the patient has been at complete rest in bed for the treatment of other affections.

It is tolerably certain that tubercular disease commences either in the articular bone or in the synovial membrane, and that it is never primary in either the cartilages or ligaments. In some joints, *e.g.*, the knee, the synovial membrane is the starting-place in the large majority of cases; in other joints, *e.g.*, the hip, the bone appears to be primarily affected in most instances.

Taking the knee as a good example of a hinge-joint, and as one in which the disease is often primarily synovial, the following changes may be described:—

The synovial membrane becomes swollen, soft, and succulent. Its colour changes to a greyish tint, and, on section, it appears gelatinous. The surface remains smooth for some time, but gradually assumes a roughened or shreddy appearance, and in time becomes converted into true granulation tissue. As the disease advances, the membrane becomes soft, pulpy, and friable, and here and there minute masses of caseous matter develop. The synovial secretion is very slightly increased, and there is seldom more than an ounce or so of fluid in the synovial cavity. The fluid is, however, altered in quality, being opalescent from

admixture with the products of inflammation, and for the same reason containing shreds of fibrin which tend to be deposited on the synovial membrane and cause in part the roughened surface of the latter. The general swelling of the articulation in such cases is, therefore, not the result of effusion into the joint, but of the swollen state of the synovial membrane itself; and it is to the same cause that we must attribute the obliteration of the fossæ on each side of the patella, and the concealment of the normal bony prominences.

When fully established in the synovial membrane, the disease soon extends to the **cartilages.** In the

FIG. 75.

Ulceration of the Cartilages of the Lower Articular Surface of the Femur.

earlier stages the latter are simply overlapped at their margins by the swollen membrane, which can easily be lifted off; but, as the inflammatory process extends, the synovial membrane becomes adherent to the margins of the cartilages, and cannot be separated without tearing its structure. If this be done, it will be found that the subjacent cartilage is pitted and ulcerated. The inflammatory process has extended from the soft parts, the cartilage has been vascularized by offshoots of the synovial vessels, and in it the same slow, but persistent destructive changes have commenced.

By a continuance of these changes the whole depth of the cartilage is ulcerated through, and the **bone** in its turn is affected. Osteitis supervenes, and the femur, patella, or tibia, as the case may be, becomes the seat of strumous caries, with its accompanying rarefaction and destruction of the cancellous bone, its caseation of inflammatory products, and its absence of formation of new bone from the periosteum. A clinical examination of a strumous knee-joint often gives the impression that the bones are thickened, and in former times it was customary to speak of "expansion" of the articular ends. It has already been pointed out, at p. 248, that inflamed bone never truly expands, and it may be added that in cases such as those under consideration the feeling of enlargement of the bone is almost always delusive, and that an examination of the parts after removal shows that there is usually no formation of sub-periosteal new bone, but merely thickening and inflammation of the superjacent soft tissues.

The **ligaments** share in the general destruction. Inflammatory exudation separates their fibres, and destroys their normally dense structure. They soften, become shreddy, and gradually stretch, or ulcerate away.

The whole of the changes described above may occur without the formation of any collection of pus, but this is not usually the case. Inflammatory processes extend to the neighbouring soft tissues, and chronic abscesses either originate in them, or else the softened synovial membrane yields an exit to some of its secretion, and the abscess in the soft tissue directly communicates with the synovial cavity, or with some portion of it which has been shut off by adhesions. When these abscesses burst, and their contents are exposed to contamination by the external surroundings, the formation of pus in them is often greatly *increased* on account of a more acute inflammation *of the* abscess-sac. In some cases this profuse for-

mation of pus subsides after a few weeks; in others, it continues for many months.

The position of the diseased joint is always one of flexion, and many theories have been originated to account for the fact. It may be stated at once that the position of flexion is not limited to the knee, but that all diseased joints are liable to be flexed. The most simple explanation, and I believe the only true one, is that it is the normal position of "rest," and is the one in which there is least pain. A moment's reflection is sufficient to convince any one that, even in a state of health, flexion is the natural position of rest, and that it is the one in which all textures are most relaxed—in which there is the least tension.

A different explanation is, however, given by some writers. It is stated that when the terminal filaments of the articular nerves are irritated, there is a general tendency to reflex muscular contraction, and that those muscles which are the strongest prevail; the supposed greater strength of the flexors of the knee is therefore held to account for the bent position.

Other surgeons have experimented by injecting fluid into the capsule of the knee or the hip of a dissected limb, and have shown that when the capsule is distended the joint in question is mechanically flexed. This also has been adduced as an explanation of the flexed position of a diseased articulation, but is evidently insufficient. In strumous cases there is practically never acute distension of the capsule, and, on the other hand, in some cases of great effusion—*e.g.*, in hydrarthrosis—there is no flexion at all. There is indeed no sufficient reason for believing that in strumous disease distension of the capsule ever *mechanically* causes flexion, but I have no doubt that if effusion is present it induces flexion indirectly, for, as I have already said, the joint is *reflexly* placed in the position of rest and of least tension.

As the ligaments yield and the bones ulcerate away, the tibia becomes displaced backwards, partly

by its own weight and partly by the continued action of the ham-strings. Further, by reason of the tendency that the lower extremity always has to rotate outwards if the continuity of its bony supports is in any way interfered with, and perhaps on account of the contraction of the strong biceps muscle, external rotation commonly ensues, and finally the articular surface of the tibia is to a great extent displaced from that of the femur.

The muscles of the thigh and leg are always atrophied in cases of strumous disease of the knee, and on account of this atrophy, which affects their length as well as their thickness, it becomes impossible after a time to replace the dislocated bones in their normal position. This difficulty is enhanced by the fact that after some length of time the other soft tissues besides the muscles accommodate themselves to the altered position of the parts, and become proportionately shortened on the side of flexion. The tibia and femur in cases of long-standing disease also waste, and cease to develop naturally—a condition which is of much clinical importance in considering the advisability of performing the operation of excision on such a joint.

A microscopical examination of the tissues in a strumous joint shows that the process is of a tubercular nature.

The synovial membrane is infiltrated with inflammatory products, which tend to undergo caseous degeneration and to form small collections of pus. The endothelial lining of the synovial membrane is destroyed, and the interstitial granulation tissue comes to the surface, and discharges its secretion into the synovial cavity. In the midst of this inflamed tissue are numerous primitive tubercles, with their giant-cells and lymphoid reticulum. Tubercle bacilli are also to be found in some cases, but in my own experience they are met with only in very small numbers.

The ligaments are infiltrated with cells, by which their structure is slowly destroyed.

The cartilages are vascularized by ingrowths from the contiguous synovial membrane, their matrix is broken up and eroded by the exuded leucocytes, and the cartilage-cells themselves multiply and undergo fatty changes. The alterations in the osseous tissues are similar to those already described as occurring in strumous osteitis.

HIP DISEASE.

The term "hip disease" is used in a general way to imply strumous disease of that articulation, and it is better not to apply it to cases of simple synovitis or acute suppurative arthritis. The process may originate in the synovial membrane, and in that case does not materially differ in its general characters from similar disease above described as attacking the knee.

Hip disease, however, commonly commences in the bones, and originates as a chronic strumous osteitis.

In the femur the disease commences in one of the following localities—(*a*) the cancellous tissue immediately beneath the articular cartilage; (*b*) the centre of the head in the immediate vicinity of the centre of ossification; (*c*) the new bone at the margins of the epiphysial cartilage between the head and neck; or (*d*) in some other part of the neck within the capsule. In the acetabulum the inflammation attacks first the most recently formed bone in the neighbourhood of the Y-shaped cartilage.

In whatever part of the bones the osteitis commences, it gradually extends until it reaches the surface. Thus, it may extend laterally through the neck, and, by separating the head of the bone from the cartilage of the epiphysis, may cause it to be cast loose into the articular cavity as a sequestrum, or, commencing in the neck, may pass outward until it reaches the periosteum, may penetrate the latter, and thus reach the articular cavity. Beginning, as it most often does,

in the cancellous tissue of the head itself, it penetrates to the under surface of the articular cartilage, and sets up inflammatory processes in the latter, which result either in its perforation by ulceration or in its separation in a necrosed condition. In any case the synovial membrane and ligaments become secondarily affected, and a general strumous arthritis supervenes. As the process continues, the cancellous tissue forming the head of the bone is slowly destroyed, the margins of the acetabular cavity ulcerate away, and the acetabulum itself becomes carious. The head of the bone may now sink into, and penetrate, the carious floor of the acetabulum, or, as is more usually the case, may be gradually displaced upwards over the broken-down acetabular margin on to the dorsum ilii, a change of position often accompanied by a corresponding extension of the carious process to the compact bone of the ilium itself. In other cases, this displacement of the femur is the result of a separation of the head of the bone, the neck, no longer catching in the acetabulum, being readily displaced by the contraction and tension of its attached muscles.

FIG. 76.

Portion of a Femur from a case of Hip Disease. The cartilage of the head has been destroyed; the bone is rough and carious, and the epiphysis of the head has become separated. The shaft is roughened by the formation of periosteal new bone.

The formation of abscesses is of common occurrence in cases of advanced hip disease. If the pus is first formed within the joint, it makes its exit either at the cotyloid notch, at the thin posterior portion of the *capsule*, or else into the bursa beneath the psoas *muscle*. Such abscesses point most often on the

upper part of Scarpa's triangle, but not infrequently they pass to the outer side of the limb, and come to the surface a little below the trochanter. In other instances, especially when the ilium is much diseased and the acetabulum perforated, an iliac abscess forms, and points above Poupart's ligament. More rarely, the pus makes its way into the cavity of the pelvis, and opens into the rectum or bladder; or, when the shaft of the femur is affected, extends to a considerable distance down the thigh.

The natural **position** of the limb is much altered in hip disease, and that in a very characteristic manner. In the early stages the thigh is flexed, abducted, and rotated outwards. This position is the one which gives the patient most ease, and is the natural position of the lower extremity when at rest. Flexion relaxes the ilio-femoral ligament; abduction, the ligamentum teres; and rotation outwards, the inner portion of the capsule. In the later stages, when the ligamentum teres has been softened or destroyed and the capsular and other ligaments are stretched, the rotation outwards and abduction are replaced by rotation inwards and adduction, for in the relaxed state of the ligaments the latter position tends to relieve pain by displacing the head of the bone from the floor of the acetabulum, and so preventing pressure between the opposed carious surfaces.

In consequence of the altered relations between the femur and the innominate bone, and the fixation of the hip-joint by the muscles, the patient is led to the adoption of certain positions in order to enable him to put the foot to the ground. The hip-joint being fixed in a state of flexion, the mobility of the lumbar spine is brought into play, and the flexed limb is placed in a line with its fellow by rotating the pelvis on its transverse axis and arching forward the lumbar spine (lordosis). If the femur is abducted, the pelvis is tilted downwards, so that the anterior superior spine of the diseased side is placed on a lower level than is that of

the opposite side, and the limb, when the patient is placed in a recumbent posture, is "apparently lengthened." If, on the other hand, the femur be adducted, the pelvis is tilted upwards until the thigh is placed parallel with its fellow; the iliac spine is thus placed on a higher level than is that of the sound side, and "apparent shortening" results.

Real lengthening of the limb in hip disease probably never occurs, but real shortening is produced either by absorption of bone, or by disease of the epiphysial cartilage and consequent arrest of growth. It is important to remember that, after all active disease has subsided, a limb may grow more slowly than that of the healthy side, and that, when a child has recovered without any shortening, it does not follow that in the future the limb will be as long as its fellow.

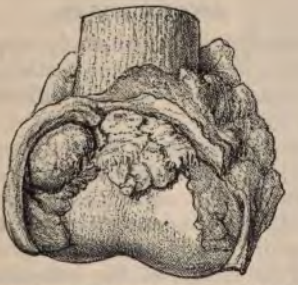
In any case of strumous joint disease, a natural cure may result, the limb either completely recovering, or being fixed by anchylosis (see p. 342). In many instances, however, in which the disease has not been treated in an early stage, the patient loses his life. A fatal termination may be brought about in one of several ways.

In some patients, death results from exhaustion, arising from the constant pain and want of rest, combined with the suppurative or hectic fever which accompanies the formation of large quantities of pus. In others, amyloid disease of the liver, kidneys, and intestines supervenes, and in the remainder acute tuberculosis or tubercular phthisis terminates the case.

The fact that tubercle is present in the joints in the majority of cases of strumous disease is naturally of great clinical importance, and affords a ready explanation for the occasional development of a more general tuberculosis. Many surgeons, acting upon the assumption that the danger of general infection is considerable, have therefore advised the early excision of all strumous joints. There can, however, be no doubt

that treatment founded on such ideas is not supported by pathological investigations, and it is quite certain that the dangers of general tuberculosis in any case of early joint disease placed under proper treatment are very slight. On the other hand, it is now the opinion of various Continental surgeons that operative interference with tubercular joints is itself liable to promote general infection, and I have myself seen several cases in which excision has been followed by the rapid formation and diffusion of tubercle. Lastly, it should be remembered that, in even the most complete excisions, it is generally impossible to be certain of removing all the tuberculous tissues.

FIG. 77.



Knee-joint from a Man who died of Syphilis. The synovial membrane is thickened and infiltrated by gummatous deposit.

SYPHILITIC DISEASES OF THE JOINTS.

Syphilis may affect the joints in one of three ways—(1) In the early periods of the constitutional affection, at the time when the patient is suffering from the so-called secondary symptoms, one or more articulations may be the seat of a sub-acute synovitis. There are no records of post-mortem examinations of such joints, but it is probable that the changes in them do not differ from those met with in cases of simple serous *synovitis.*

(2) In the later stages of syphilis, at a time when the patient is subject to gummatous or rupial ulcers, to necrosis or caries of the bones, &c., the synovial membrane may be the seat of inflammatory effusion, and gummatous masses may develop in the synovial and sub-synovial tissues. In such cases there is much thickening of the affected parts, and considerable destruction of the articular structures. (See Fig. 77.)

(3) The articular extremities of the bones may be affected in a manner similar to the shafts, and an inflammation, commencing in the periosteum, may extend to the neighbouring joint.

Considering the prevalence of syphilis, the joints are comparatively rarely affected in this disease.

ANCHYLOSIS.

The term anchylosis is commonly employed to indicate a condition of complete, or partial, immobility of a joint, due to adhesions between different portions of the articular surfaces.

In all cases anchylosis is the result of pre-existing inflammation, and the extent, position, and density of the adhesions depend upon the tissues which have been involved in the inflammation, on the amount of destruction which the tissues themselves have undergone, and on the nature of the inflammatory process. Where the inflammation has been acute, and has progressed to the formation of pus in large quantities, as in acute suppurative arthritis, the anchylosis is liable to be very firm and bony, whilst in cases of simple chronic synovitis there is usually no attempt at the formation of any adhesions. In strumous disease, where there is little tendency to repair, anchylosis is liable to be not very firm, whilst in osteo-arthritis anchylosis never results.

In those cases where the inflammatory processes have involved the synovial membrane, the ligaments, and the cartilages only, the adhesions are composed *of fibrous* tissue; but, where the bones have been

affected, and especially when there has been suppuration, bony anchylosis or osseous union of two granulating surfaces is common.

Adhesions may be formed in the following ways:—

(1) If two layers of synovial membrane in a state of inflammation are kept in constant apposition, their surfaces may become united by fibrous tissue, just as may the opposed surfaces of the pleuræ. Thus, in the knee-joint it is common to find the anterior and posterior surfaces of the synovial pouch beneath the quadriceps tendon adherent, and the pouch in many cases obliterated.

FIG. 78.

An Anchylosed Knee-joint. The patella is fixed to the femur by bone, but the rest of the anchylosis is by fibrous tissue. The tibia has been dislocated backwards to a considerable extent.

(2) Two opposed surfaces of ulcerating cartilage may be united by the development of fibrous tissue between them; *e.g.*, the patella may be fixed to the external condyle of the femur.

(3) Inflammatory exudation into the ligaments may become developed into fibrous tissue, and the latter, by its subsequent contraction, may interfere with the proper movements of the articulation. Thus, in disease of the knee, when the joint has long been kept in a state of flexion, the posterior ligament of Winslow may be found permanently thickened and contracted, and may frustrate all attempts at complete extension.

(4) Two opposed osseous surfaces in a state of inflammation may join to one another by bone in the *same manner as the* ends of a bone unite after a

fracture. Sometimes this union is so complete that the two bones are welded together in such a manner that their line of junction cannot be distinguished. To such a condition the name of "synostosis" has been applied.

In addition to these varieties of anchylosis, it must be remembered that spurious anchylosis, or fixation of a joint by changes in the tissues outside it, is of common occurrence. This may be brought about in various ways.

FIG. 79.

Hip-joint showing Complete Bony Anchylosis.

(*a*) Where a joint is diseased, the muscles which regulate its movements cause partial or complete immobility by tonic reflex contraction, and thus prevent the patient from suffering the pain which would result from friction between the articular surfaces.

(*b*) Inflammatory exudation around a joint may cause thickening and adhesion of the peri-articular tissues, such as the tendons, muscles, or fasciæ.

(*c*) In cases where a joint has been long maintained in a bent position, the soft tissues on the side of flexion accommodate themselves to the altered position of the bones, and finally become too short to allow of complete extension. This condition may often be seen in cases of long-standing disease of the knee-joint, and is liable to cause much difficulty in cases of excision.

CHAPTER XLI.

DISEASES OF THE PENIS AND SCROTUM.

ECTOPIA VESICÆ AND EPISPADIAS.

OPIA VESICÆ, or extroversion of the bladder, con- s of a deficiency of the anterior vesical wall, and he corresponding part of the abdominal parietes, results from failure in closure of the lower part he fœtal body-cavity.

n such cases, the bladder, being incomplete in it, fails to act as a reservoir, and the urine escapes apidly as it passes from the ureters. The posterior cal wall is thrust forward, just above the pubes, he pressure of the abdominal viscera, and presents ucous surface, which is often swollen and in- ed, either on a level with the surrounding skin else protruding in front of it. On this surface orifices of the ureters may be seen, the urine being ed from them at short intervals in minute jets. urethral orifice is always imperfect, and the penis f is small and in a condition of "**epispadias,**" corpora cavernosa being cleft and the roof of the hra undeveloped, so that the urine flows along a low groove instead of through a mucous canal. pubic bones are usually separated in the middle by a considerable interval, the recti muscles con- ently diverging to reach their attachments. The s are commonly retained, and inguinal herniæ

are of frequent occurrence. The deficiency in the abdominal wall extends as high as the umbilicus.

HYPOSPADIAS.

Hypospadias is the term applied to a cleft condition of the floor of the urethra, which forms a groove instead of a canal on the under surface of the penis. It results from imperfect fusion of the two sides of the uro-genital aperture, which in early fœtal life forms an antero-posterior slit or fissure at the lowest part of the abdomen.

In the female, this fissure does not close, and, while its two lateral boundaries form the labia, the clitoris is developed at its anterior commissure. In the male, the two halves normally unite, forming the scrotum below, and closing in the floor of the urethra anteriorly.

In slight forms of hypospadias, the glans and prepuce alone are cleft. In more severe cases the urethra is opened up as far back as the scrotum, whilst in complete hypospadias the fissure extends as far back as the membranous urethra, the scrotum being divided in the middle line. In such cases as these the cleft scrotum, with its contained testes, closely resembles the labia, and the penis, being very imperfectly developed, aids the delusion. It is by no means uncommon for male children with this deformity to be brought up as females, the error not being discovered until the period of puberty approaches. When hypospadias is slight, it causes no inconvenience, but in those cases where the whole urethra is affected the penis during erection is curved downwards, and connection is rendered impossible.

PHIMOSIS.

The term phimosis is employed to indicate any condition of the prepuce which prevents its retraction *over the* glans penis. In the great majority of cases *phimosis* is a congenital defect, and one which often

es rise to troublesome symptoms. It causes re-
tion of the secretion of the sebaceous glands in
neighbourhood of the corona glandis, and con-
uent continued irritation from the presence of the
ained matter. If the condition is not relieved,
under surface of the prepuce is liable to become
erent to the glans. Vesical irritability, with fre-
nt micturition, straining, prolapse of the rectum,
l nocturnal incontinence of urine are amongst the
st frequent troubles which arise from this affection.
Phimosis may also result from inflammatory swell-
in connection with gonorrhœa or venereal sores, but
hen usually transient. In some cases, however,
contraction of a cicatrix causes permanent narrow-
of the preputial orifice, and in old men the same
dition is liable to supervene upon the cracks and
ures which are not infrequently met with on the
puce.

PARAPHIMOSIS.

Paraphimosis results from retraction of a tight
puce behind the corona glandis, where it remains
d. Paraphimosis may occur in connection with a
genitally tight preputial orifice, but it more often
lows upon retraction of an inflamed prepuce in a
e of gonorrhœa. In consequence of the constriction
the glans by the tight preputial orifice, it becomes
gested, whilst at the same time the constriction
o tightens and the prepuce becomes swollen and
lematous. If the condition be not relieved, the
ht preputial orifice usually ulcerates or sloughs in
me part of its circumference, but the glans penis
elf hardly ever becomes gangrenous.

EPITHELIOMA OF THE PENIS.

Epithelioma of the penis, as of other parts, occurs
efly in old men. It almost invariably commences
the prepuce or the glans, and is very rarely seen
a primary affection of the body of the penis,

Phimosis, or cracks and fissures of the prepuce, are generally believed to act as predisposing causes.

Commencing as a warty growth, the increase of the epithelioma is generally rapid. Its surface soon ulcerates, and the deeper tissues become at an early stage infiltrated and indurated. If left alone, it extends along the corpora cavernosa and the corpus spongiosum to the perineum, and subsequently to the neck of the bladder. Obstruction to the outflow of urine, with severe cystitis, supervenes, and life is often terminated by kidney disease resulting from the foul and unhealthy state of the bladder. The inguinal glands are early enlarged by formations in them of secondary growths, and in many cases similar disease extends to the deeper lymphatic glands along the iliac vessels and in the lumbar regions. Deposits may also form in the viscera, but are not of common occurrence.

Innocent tumours of the penis are rare, and do not require special mention. Venereal warts are treated of in the chapter on Gonorrhœa.

CHIMNEY-SWEEP'S CANCER—EPITHELIOMA OF THE SCROTUM.

The occurrence of epithelioma of the scrotum is undoubtedly caused by the habitual presence of soot in its rugæ, and it may be mentioned that, in sweeps, epitheliomata appear specially liable to develop on other parts of the body. It is commonly stated, and believed, that epithelioma of the scrotum is becoming less common, but it is doubtful whether this is really the case.

The disease commonly commences as a wart, which, after a time, ulcerates and extends, as do epitheliomata in other parts. Even when apparently a simple wart, the disease is really of a malignant nature, and I have had opportunities of verifying this statement by microscopical examination of growths no larger than a split pea. If untreated, the

growth extends to the perineum and penis, in much the same manner as when epithelioma commences in the latter organ. The inguinal glands are also early occupied by secondary growths which may also become disseminated in the viscera.

Innocent tumours of the scrotum are comparatively rare, and are of no special importance. The most common of them is the soft fibroma, which occasionally attains a considerable size.

CHAPTER XLII.

GONORRHŒA AND STRICTURE.

GONORRHŒA.

GONORRHŒA is a specific inflammation of the urethra and contiguous parts, and is always transmitted by contagion. Before entering into a description of gonorrhœa, however, it may be pointed out that all forms of urethritis are certainly not of gonorrhœal origin, many of them being due to infection by irritating secretions from the vagina or uterus, or to the passage of instruments.

The inflammation, originated by the application of gonorrhœal pus to the glans penis and orifice of the urethra, often extends along the whole length of the passage, though it is usually most intense in the fossa navicularis. The mucous membrane is swollen and intensely injected, and a secretion, at first of mucus and serum, but very soon of pus, is rapidly established. The amount of pus discharged is usually very great, and in some cases the distended capillaries give way and allow a discharge of blood. After lasting for a week or more, the acute inflammation slowly subsides, the discharge becomes less abundant and less purulent, and, after persisting as a watery exudation for a variable time, finally entirely ceases.

During the height of the attack, the corpus spongiosum is itself infiltrated with plastic effusion and the whole penis is swollen and tender. There is usually much pain, and increased frequency of

ition, often accompanied by a good deal of feve
ɜ swelling of the urethral mucous membran
quently causes some difficulty of micturition, an
asionally induces complete retention of urine.
nful erections of the penis, or "chordee," are an
ıost constant accompaniment of the acute stage,
l are characterized by distortion of the organ so
t it forms a curve, with the concavity downwards.
s condition results from the presence of plastic
dation in the corpus spongiosum, and a consequent
rference with its erectile tissue.

COMPLICATIONS OF GONORRHŒA.

The complications of gonorrhœa are so numerous
t it is impossible to describe all of them at length,
they are of sufficient importance to require some
ıtion.

As regards the penis itself, either phimosis or
aphimosis may arise, as already described, and
ammation of the prepuce (posthitis) and of the
ıs penis (balanitis) are of frequent occurrence.
ammation of the lymphatics of the penis, and
lized inflammatory induration of the corpus
ngiosum or corpora cavernosa, are more rare.
rty growths about the prepuce and glans gene-
y result from want of cleanliness in cases where
discharge has lasted a long time.

Inflammation of the lymphatic glands in the
in is common, and is very liable to terminate in
puration or the formation of a "bubo." The pus
ned in the glands under these circumstances has
the characters of the gonorrhœal discharge, and
resulting ulcers are consequently unhealthy and
le prone to heal. In rare cases the glands in the
ɔ fossa are affected, and deep-seated suppuration
ıes.

Epididymitis and **orchitis** are amongst the most
ımon of the complications of gonorrhœa, and are
e prone to develop in the second or third week

than at an earlier date. They probably result from a direct extension of the inflammation from the prostatic urethra to the ejaculatory ducts and the vas deferens, but are considered by some authors to be of metastatic origin. In many cases the onset of the epididymitis is followed by a diminution of the urethral discharge, and its subsidence by a return of the urethritis. For further details the chapter on the Testes may be consulted.

Urethral or peri-urethral abscess is to be placed among the rarer complications of gonorrhœa. It may develop along any part of the corpus spongiosum, but is most common in the perineum and close to the urethral orifice. Such abscesses are supposed to result from suppuration around one of the lacunæ in the urethral floor. If opened early, they do not usually communicate with the urethra, but, if left alone, they are liable to open into the latter.

Acute and chronic **prostatitis** are fortunately comparatively infrequent. They are more fully described in the chapter on the Prostate.

Cystitis in its milder form is not uncommon, whilst acute cystitis, though rare, is a most serious and dangerous complication. ' Exceptional cases have been recorded of extension of inflammation along the ureters to the kidneys, with consequent pyelitis and nephritis.

Gonorrhœal ophthalmia is one of the most acute and serious forms of inflammation to which the eye is subject. Commencing in the conjunctiva, the inflammation rapidly extends to the cornea and sclerotic, is accompanied by much purulent discharge, and is liable to terminate in sloughing or ulceration of the cornea, and consequent destruction of the entire globe. It is most probable that gonorrhœal ophthalmia is always the result of contagion by gonorrhœal pus, and it is evident that the other eye is very prone to be implicated by inoculation with the discharge of its *fellow*.

Gonorrhœal **sclerotitis** is usually associated with gonorrhœal rheumatism, and, beyond being exceedingly intractable and chronic, does not differ from sclerotitis arising from other causes.

Gonorrhœal rheumatism has already been dealt with in a previous chapter.

Gonorrhœa in women is rather an inflammation of the vagina than of the urethra, although the latter is also frequently implicated. Its complications are much the same as in the male, but differences arise, of course, in connection with the different parts involved.

Inflammatory œdema of the vulva is sometimes very marked, and the swelling great. Vulvar abscesses are also common. In rare cases the cavity of the uterus is involved in the inflammation, which may also extend to the Fallopian tubes. Ovaritis is probably more common than is generally supposed, and peritonitis occasionally results from extension of inflammation from the ovaries or the tubes. Chronic suppuration of the tubes, with distension by pus, or "pyosalpinx," and consequent formation of adhesions to surrounding parts, is usually considered to result from gonorrhœa more frequently than from any other cause.

STRICTURE OF THE URETHRA.

Stricture of the urethra, or narrowing of its calibre, is commonly described as of three varieties—(1) congestive; (2) spasmodic; (3) organic. In the present chapter, it is to the last of these varieties alone—the organic—that the term will be applied. Congestive stricture is but another name for inflammatory swelling of the mucous membrane, such as has already been described as occasionally causing retention of urine in gonorrhœa. Spasmodic stricture does not exist *per se*, though spasm may complicate either an organic stricture or any irritated or inflammatory condition of the bladder *or urethra*.

Organic stricture is a narrowing of the urethra by the formation of fibrous tissue, and results almost invariably from gonorrhœa or from injury. It has already been said that, after the acute inflammatory stage of gonorrhœa has subsided, a chronic urethritis, or "gleet," is apt to persist for some time. It is to this chronic inflammation of the urethra, rather than to the acute urethritis, that the organic stricture is to be attributed. All chronic inflammations are more liable to cause the formation of fibrous tissue, and consequent induration and thickening, than are acute attacks, and thus the urethra is narrowed by the contraction of scar-tissue formed in its walls.

FIG. 80.

A Urethra laid open, showing a stricture about 2 inches from the meatus.

In cases of laceration, also, the torn urethra is mended by a scar of fibrous tissue, and this, like all other scars, tends to contract, and thus to narrow the tube. These strictures, which are named **traumatic,** are almost always situated in the bulbous or membranous urethra, and are often very tight and not easily dilatable.

Strictures resulting from gonorrhœa may affect any part of the urethra. Those seen in museums are most common in the membranous and bulbous portions, but the less severe varieties, which do not so often find their way into museums, are at least as common, if not more common, in the penile urethra. The prostatic urethra is never the seat of stricture.

Strictures are sometimes classified according to the amount and arrangement of the fibrous tissue of which they are composed. Thus, when the latter forms a

ow ring round the canal, the stricture is called ılar; when it surrounds the tube for a greater ion of its length, tubular; and when bands of ıs pass across the lumen of the tube from one to another, the term bridle stricture is employed. tricture is generally narrower and less dilatable greater the amount of its fibrous tissue, and to e strictures in which the urethra is buried in a ı of cicatricial tissue the term cartilaginous is ied, on account of their great density and ness.

'ith regard to the position of a stricture, it may ıid that the nearer it is to the meatus the less ble is it of dilatation, and strictures of the meatus f often yield only to cutting. These strictures not ıquently result from venereal sores.

EFFECTS OF STRICTURE.

ıe effects of stricture on the urinary organs are y and serious. They are usually in proportion ıe amount of obstruction to the passage of urine, may be to a great extent prevented by proper ;ment. Many slight strictures are never followed ny serious complications.

ıe **urethra** behind the stricture is in some cases ɛened, for its muscular coat hypertrophies in order ɾercome the obstruction. More often the tube is ed by the backward pressure of the urine, and is ɪtimes much pouched.

ıe mucous membrane is often in a state of chronic mmation, and is not infrequently ulcerated and ed, the lacunæ being enlarged and forming little ets in which urine and inflammatory exudation ct. In bad cases the inflammation extends to tissues around the urethra, and results in the ation of pus in this situation. In other cases ation completely penetrates the urethral walls, a peri-urethral abscess is formed. This abscess me makes its way to the surface, and bursts, thus

establishing a communication with the exterior, and forming a **urinary fistula.** In these cases extravasation of urine is prevented by the plastic effusion into the peri-urethral tissues, but if the thinned and ragged urethra yields suddenly during the act of micturition, or if the walls of the abscess are thin, then the urine is propelled through the rent in the urethral walls, with all the force of an hypertrophied bladder, into the cellular tissue.

The urethra almost always gives way in the membranous or bulbous portions, and the urine, guided by the attachments of the fasciæ, infiltrates the scrotum, penis, and abdominal walls, causing sloughing of the cellular tissue wherever it extends. In bad cases large portions of the urethra itself may slough.

Retention of urine does not result from obliteration of the urethra, but is always brought about by some complication.

It has already been said that the mucous membrane in the neighbourhood of the stricture is often inflamed, and it is easy to understand that anything which causes an increase of this condition, *i.e.*, anything which excites active congestion, may induce such an amount of swelling as to temporarily block up the already obstructed tube. In addition to this, spasm of the muscles at the neck of the bladder or of the urethra itself, may result from the congestion, or from an acid state of the urine. Again, where there is any peri-urethral inflammation or collection of pus, the pressure of the inflammatory products may obstruct the flow of urine. It will thus be seen that the final cause of retention is almost always some local spasm, congestion, or inflammation, and a knowledge of this is the true key to all efficient treatment. Such conditions are usually transient, and, when they have subsided, the urine is often again voided voluntarily, and instruments which could not previously be *passed* are readily introduced.

However long urine is retained, the bladder hardly

ever gives way. In cases of stricture, this viscus is usually hypertrophied, and by its involuntary contractions, not only causes the patient much pain, but also over-distends the urethra behind the stricture. It is in consequence of these conditions that in bad cases of retention the urethra bursts, and the urine is extravasated.

FIG. 81.

A Penis with a Stricture of the Urethra in the Membranous Portion. The bladder-walls are greatly hypertrophied.

The bladder in all long-standing cases of stricture becomes hypertrophied — a condition which results from the increased force required to expel the urine. The muscular coat of the bladder is normally arranged in interlacing bundles or fasciculi, and as these become greatly increased in size in all cases of hypertrophy, and are seen as prominent bands beneath the mucous membrane, the term **"fasciculated"** is often applied to such bladders. On account of this arrangement of the muscular coat, the mucous membrane between the different fasciculi is insufficiently supported, and, when the bladder contracts and the tension of the fluid in it is raised, the mucous coat tends to yield, and to herniate or protrude between the bundles of muscular fibres. Such a protrusion is called *a* ***"sacculus,"*** and a bladder so affected is *said to be* ***"sacculated."*** Sacculi vary much in size,

and are sometimes sufficiently capacious to hold as much as a pint of urine. However large they may be, their orifice of communication with the bladder is always small. They are liable to cause much trouble, for, having no muscular wall, they are unable to empty their contents satisfactorily, and urine remaining in them is liable to decompose and so to keep up cystitis. In other cases the sacculi contract adhesions to the intestines and other neighbouring structures.

The thickened bladder is often the seat of **cystitis**, and, where this has been of long standing, the mucous membrane is much pigmented, and of a dull slate colour. Ulceration is not common. The dilatation of the ureters and disease of the kidneys, which may follow on stricture, are described in the following chapter.

CHAPTER XLIII.

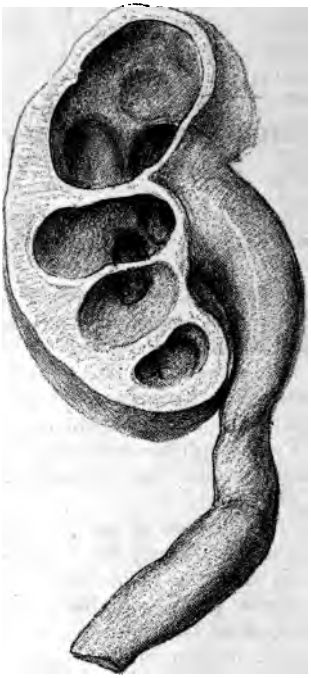
ɪRGICAL KIDNEY—PYELO-NEPHRITIS.

ı surgical kidney has long been applied to s in which the renal organs become diseased ult of some obstruction to the outflow of m the bladder, but precisely similar patho- ıditions may result in a single kidney from anical blocking of its ureter. The name is , for it seems to indicate that such kidneys m surgical interference, whereas the reverse ɜ: they result from want of proper surgical ɔ. Pyelo-nephritis has of late been suggested ernative name, but is itself not altogether objection.

s.—The diseases of the urethra and bladder ıse surgical kidney act in more ways than rst, it may be said that any persistent of these parts is liable to cause reflexly yperæmia of the kidneys—a condition which, ɔlonged, results in cell exudation and the ı of fibrous tissue between the tubules, and ses "interstitial nephritis." Second, any- ich obstructs the outflow of urine from the ends to obstruct the exit of urine from the ıto the bladder. At first sight this does not ıite clear, for the cavities of the ureters are ɪtly continuous with that of the bladder, fices being valvular and never becoming

dilated. Why, then, should they have difficulty in emptying their contents? The answer is twofold. First, obstruction to the exit of urine causes hyper-

FIG. 82.



A Kidney and Ureter. The pelvis and calices are dilated, and the renal tissue has been in great part absorbed. The ureter also is much distended. (From a patient who died with a large calculus in his bladder.)

trophy and induration of the bladder-walls, and, as the ureters pass obliquely through the thickened tissues, they are thus subjected to compression. Second, if the bladder is frequently over-distended,

ension within it is so greatly raised that it is ılt for more urine to find an entrance. In both ways the urine is retained under pressure .e ureters, and these tubes become first hyper- ıied and afterwards distended. But the ureters irectly continuous with the pelves and calices of idneys, and thus these also are distended by the ıed urine. This distension of the renal cavities s chronic irritation of the kidneys, and so ıtitial nephritis, as well as absorption of the lular tissue itself. It is a rule of pathology that ant pressure induces atrophy, and the pressure e retained urine causes atrophy or absorption of ›yramids, whilst it simultaneously distends the ɜ and calices, and in time reduces the gland to a :tion of cysts bounded only by the distended .le and by thin septa of renal tissue.

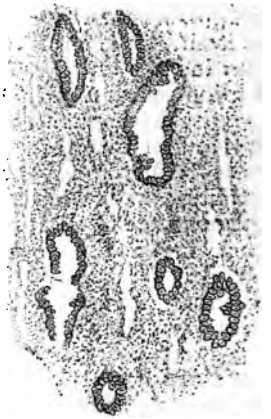
orbid appearances.—Examination of the ›ys and their ureters in these cases shows a ty of conditions, for whereas, in some, inflam- ry changes with induration and contraction ıil, in others the effects of distension are most ed.

us, the **ureters** are thickened both by an ase of their muscular coat and by the formation ›rous tissue. They may be distended in very ng degrees. It is common to find them as large crow-quill, but in exaggerated cases they may ɜ the size of the œsophagus or of a piece of small ;ine. The more they are dilated, the more ous and pouched do they become. The longer :he more often they have been inflamed, the ır and more pigmented does their mucous lining ır.

ıe **kidneys** are generally found to be unusually ent to the fat in which they lie. When chronic ıtitial nephritis has been more marked than ısion of the pelvis and calices, the glands are ; when the latter condition has prevailed, they

may be distended to almost any size. The capsules are usually adherent. Small cysts, the size of peas, are found in the cortex, and result from the dilatation of tubules which have been obstructed by the pressure of the surrounding fibrous tissue. On section, the renal tissue is found to be tough and resistant, the cortex is irregular and puckered, and the renal

FIG. 83.



Section through the Cortical Portion of a Surgical Kidney. There is much increase of connective tissue, and the remaining renal tubules are undergoing cystic dilatation. (Zeiss, A.)

substance itself is more or less atrophied, as already explained.

On **microscopical examination,** the fibrous stroma of the kidney is seen to be increased in quantity, the renal tubules being separated from one another by a growth composed of small cell exudation and of connective tissue of varying density. The new tissue is often very vascular, and in some cases the walls of the vessels are increased in thickness

The renal epithelium varies much in different tubes; in some it is natural, in others granular or fatty, whilst some tubules are denuded of their epithelial lining. Distension of the tubules is common, and definite cysts are often formed in the cortex.

ACUTE SUPPURATIVE NEPHRITIS.

A kidney in such a condition as that above described is liable to become at any time the seat of acute inflammation and suppuration, and to pass into a state of "acute suppurative nephritis." Suppurative nephritis usually results from an extension of inflammation from the bladder, and is often induced by an attack of retention of urine, by frequent or forcible catheterization, and by operations on the urethra or bladder. The fact is, that the kidneys in such cases are in such a precarious state that a mere trifle may throw them off their balance, and exposure to cold or wet, such as might in normal circumstances induce a slight congestion, will in these cases bring on an acute nephritis. It is for this reason that surgeons are so careful about operating on patients in whom these conditions are suspected, for the most trifling operation, especially on the urinary organs, may induce suppuration in the kidneys, and complete suppression of urine. If a post-mortem examination be made after death from such a cause, the following conditions will usually be found:—

Morbid appearances.—Both kidneys are generally affected, but one is often more diseased than the other. Each is larger than natural, and in some cases is three or four times the normal size. The capsules usually peel off easily, having become loosened by exudation beneath them. The surface of the gland is mottled. In some places it is dark and congested; in others, small collections of pus are seen thinly covered by renal tissue. A section liberates much pus mixed with urine, which usually smells *badly. The pelvis and* calices are congested, and of a

dark-purple or slate colour. The renal tissue is very soft and friable, and parallel with the renal tubes are white streaks of pus, which often lead up to the abscesses in the cortex.

Microscopical examination shows a general infiltration of the kidney with leucocytes. These are in places collected into masses, and represent areas in which the inflammation has progressed to the formation of an abscess. The renal epithelium is swollen, and the tubes are often filled with cast-off cells and leucocytes. Here and there collections of red blood-cells are found, indicating that an over-distended vessel has given way, and its contents have escaped. Micrococci are found in all parts of the section, especially in the neighbourhood of the developing abscesses.

The pathology of acute suppurative nephritis has been much discussed, and various explanations have been advanced. It appears probable that in most cases the condition is the result of acute inflammation propagated from the bladder to the pelvis and calices, and extending thence to the renal tissue; but in some the inflammation seems to originate in the renal tissue itself, and is then probably the result of acute congestion occurring in an organ already in a state of chronic inflammation.

CHAPTER XLIV.

DISEASES OF THE BLADDER.

CYSTITIS.

ITIS, or inflammation of the bladder, is chiefly with as a complication of other diseased con- ns of the genito-urinary tract, but may also nate from exposure to cold and wet, or during ourse of one of the exanthemata.

many cases it results from an extension of rrhœal inflammation from the urethra or pros- in others, from retention of urine in patients enlarged prostate or stricture of the urethra; st the irritation caused by calculi, the passage of uments, the presence of new growths, and an ting condition of the urine account for most of emaining cases.

its more **acute** forms cystitis is characterized ie appearances common to inflammation of any ous surface, namely, redness and swelling. These ges are accompanied by catarrh, and the conse- t admixture of the urine with serum, mucus, and elial débris. In bad cases the inflammation progress—ulceration may ensue, and a purulent rh be established. Occasionally, portions of the us lining slough, and sometimes false membranes liphtheritic character are formed.

ronic cystitis is characterized by the formation uch stringy and viscid mucus, and by alkalinity e urine. This state of the urine results from

the action of a ferment present in the mucoid secretion, which causes decomposition of the urea, and the formation of carbonate of ammonia. The alkaline urine in its turn keeps up the cystitis, and thus the two conditions act and react on each other. All alkaline urine contains micrococci and bacteria. It is a well-recognized fact that retention of urine is a very common cause of decomposition of that fluid, and in the opinion of some surgeons the decomposition always results from the passage of instruments and the conveyance of septic matter to the interior of the bladder. That this is a fertile source of cystitis and alkaline urine cannot be doubted, but it is certainly not correct to say that it is the invariable or even the common cause. Numerous cases of alkaline urine come under notice in which no instrument has been passed, and, to explain these, it has been suggested that mucus sticks about the urethra, and that the growth of organisms and decomposition extend along it from the meatus to the bladder. This, again, may be true of some cases, but there is no necessity to raise any such difficulties or supply such doubtful explanations. It is quite certain that micrococci can, and do, obtain access to the interior of the body independently of any wound or direct means of communication, and it is highly probable that they are incapable of doing much harm except when in contact with unhealthy tissues. There is no more difficulty in explaining the presence of micro-organisms in the inflamed bladder than in the pus of an acute abscess.

An examination of the bladder of a patient who has died with chronic cystitis generally reveals a contracted viscus with thickened walls, but it is evident that the appearances due to the chronic inflammation will often be masked by pathological changes resulting from the trouble which has itself been the cause of the cystitis—*e.g.*, stricture, enlarged prostate, &c.

The mucous membrane is swollen and thickened,

prominent veins, and areas of congestion and sub-ous extravasation. Its colour is dark grey, with hes of purple or dusky red. Phosphatic deposits often found in places, and occasionally ulcers may een about the trigone.

he urine in such a case is turbid and alkaline, ng a foul ammoniacal smell. It is mixed with us, pus, and blood, and, on standing, deposits tals of triple phosphate.

TUMOURS OF THE BLADDER.

umours of the bladder may be divided into **inno-t** and **malignant.** The latter are considerably more common.

FIG. 84.

A Bladder with a Sessile Villous Tumour.

he innocent growths may be subdivided into llomata or villous tumours, mucous polypi, and us polypi. Of these, the **papillomata** are the t common. The surface of one of these growths vered with delicate branched processes, or papillæ,

which float in water, giving it a shaggy or "villous" appearance. Each papilla, on microscopic examination, is found to consist of a delicate central stalk of very fine, loose connective tissue, in which are embedded many round and oval cells. This stalk, which contains a central, looped blood-vessel, is covered by a layer or layers of oval or fusiform epithelial cells. The whole growth is usually sessile, being attached to the bladder by a broad base, but is sometimes distinctly pedunculated. On account of their extremely delicate structure, such tumours are liable to give rise to considerable hæmorrhage.

FIG. 85.

The Bladder of a Child, showing polypoid growths which caused death by obstructing the outflow of urine.

Mucous polypi are rare, and are met with only in children. They are composed of myxomatous tissue, such as is found in the common mucous polypi of the nose. In some cases they are very numerous, covering the greater part of the vesical mucous membrane.

Fibrous polypi are also rare. They occur in children, and are liable to prove fatal by interfering

h the passage of urine, and thus inducing disease he kidneys.

Malignant tumours of the bladder are more mon than the innocent growths already mentioned. f the **carcinomata,** scirrhous cancer may be said er to occur in the bladder, whilst encephaloid wths are also rare. Epithelioma is often met with, may originate on any part of the surface of the us. It chiefly attacks men past middle age, and

FIG. 86.

A Bladder with a Large Cancerous Growth, the surface of which has ulcerated and is ragged and shreddy.

metimes seen growing on two or more separate ions of the mucous membrane. The surface of epithelioma usually ulcerates before the growth ins any considerable size, and the tumour itself, g macerated in the urine, becomes shreddy and ghened, forming what has been called "villous er." Such growths present, in their early stage, ery close resemblance to the innocent villous ours described above, but, unlike the latter, they

tend to infiltrate the surrounding tissues, and, in rare cases, cause glandular affection and secondary tumours in the viscera. Their growth is slower than is usual in epitheliomata of many other parts, and often extends over a year or two.

Sarcomata are of less common occurrence in the bladder than carcinomata. They appear to behave as do sarcomata in other situations—infiltrating, breaking down, and occasionally disseminating.

The above short description of bladder tumours would be incomplete without some reference to the effects which they produce on the urinary organs. These effects differ much according to the nature of the growth.

The innocent tumours, as a rule, cause but little vesical irritation, and often no cystitis at all. The papillomata and mucous polypi chiefly give rise to trouble by the hæmorrhage which takes place from their surfaces. This is often the only symptom which the surgeon finds to guide him, for, as a rule, they are so soft as to escape detection, both by the sound and by rectal examination. Any innocent growth, if it obstructs the orifices of the ureters or urethra, may give rise to further trouble, and produce secondary disease of the kidneys, with distension of their pelves and calices, and absorption of the renal tissue.

Malignant growths, on the other hand, usually cause much vesical irritation, and set up severe and intractable cystitis, with alkaline and foul urine mixed with blood and pus. In addition to this, such tumours are usually readily felt by instruments in the bladder, or by the finger in the rectum, for the wall of the latter viscus is often infiltrated. When a patient dies of a malignant growth in the bladder, suppurative nephritis is usually found at a post-mortem examination, and is readily explained by the extension of *inflammation* from the bladder, as well as by the *occasional* [illegible] action to the passage of urine.

CHAPTER XLV.

DISEASES OF THE PROSTATE.

PROSTATITIS.

Acute inflammation of the prostate, or "prostatitis," is commonly the result of gonorrhœa, and arises from a direct extension of the inflammation from the prostatic urethra. It may also be set up by the passage of instruments.

Prostatitis causes much swelling of the whole gland, and is accompanied by great pain, frequency of micturition, and fever. In some cases the swollen gland interferes with the passage of urine, and causes retention. In many patients the inflammation terminates in suppuration, with much brawny induration of the perineum. The pus, if left alone, may make its way in various directions. In favourable cases it bursts into the prostatic urethra, and is then evacuated with but little trouble. In other instances it passes backwards into the rectum. Sometimes, but fortunately rarely, it escapes into the cellular tissue around the prostate, and there becomes diffused, setting up general cellulitis and suppuration. It is evident that rupture in the latter situation is fraught with more trouble and danger to the patient than when the pus escapes into the urethra or rectum.

Chronic prostatitis results from an acute attack, or from gonorrhœa, stricture, or exposure to cold and wet. *It is accompanied by* slight enlargement and

tenderness of the gland, with gleety discharge, and is usually very chronic and troublesome to treat.

HYPERTROPHY OF THE PROSTATE.

Hypertrophy of the prostate is essentially a disease of late life, seldom or never commencing before the age of fifty-two years, and being much more common over sixty. It does not appear to have any definite cause.

The gland may be enlarged as a whole, all its three lobes being equally hypertrophied, or, whilst there is general enlargement, one or other lobe may be more hypertrophied than the remainder. Rarely, the increase in size affects one lobe alone.

A normal prostate is composed of fibrous tissue, gland tissue, and involuntary muscle fibre, but in the hypertrophied organ the normal proportions of the several constituents are seldom preserved. In most cases the fibrous tissue is increased far more than are the glandular and muscular structures, and the organ, consequently, is more dense and firm than natural.

The size of enlarged prostates varies greatly, but the slighter hypertrophies not infrequently cause quite as much trouble as do the more marked enlargements.

In many specimens of hypertrophied prostates definite **tumours** are found on section. These are usually firm, white, and fibrous, sometimes no larger than peas, in other cases as large as a walnut. They are surrounded by a capsule, and, on microscopic examination, are seen to be composed of fibrous and muscular tissue. Other tumours, not so white and dense, and not so definitely encapsuled, consist of a fibrous stroma in which is embedded gland tissue, whose acini are often distended so as to form minute cysts.

The effects of prostatic hypertrophy are seen in the urethra, bladder, ureters, and kidneys.

The urethra is in all cases lengthened in proportion to the size of the growth, and in some cases the

static portion of the tube measures two or three nes, instead of an inch and a quarter. On account his, prostatic catheters are made longer than others. addition to its increase in length, the urethra be- nes more or less tortuous. Thus, if one lateral lobe more enlarged than the other, it will cause the thra to bulge towards the opposite side; if the ddle lobe be enlarged, the urethral floor will be shed up from below so as to cause a convexity in

FIG. 87.

An Enlarged Prostate with an Hypertrophied Bladder. A sacculus has developed at the uppermost part of the bladder.

s situation. If there is much general enlargement, urethra becomes compressed, so that the lumen its tube is narrowed and the passage of urine interfered with. In this way retention may be used.

In the **bladder** the urethral orifice is pushed wards, so that it no longer occupies the lowest sition in the erect posture, and thus predisposes the

urine to collect in a pouch behind it. On account of the obstruction offered to the passage of urine, the vesical walls hypertrophy, and the organ may subsequently become fasciculated and sacculated, as described in a previous chapter. When the middle lobe is much enlarged, it tends to become pedunculated and to extend towards the vesical cavity. It thus

FIG. 88.

Section of a Dilated Bladder, showing the pouching of the bladder-wall which occurs behind an enlarged prostate. A bristle has been introduced into the left ureter.

becomes a very prominent cause of difficult micturition and retention of urine, for it not only lies directly over the urethral orifice, but tends to be thrust down as a valve over that orifice by the pressure of the urine in attempts at micturition.

As time goes on, and micturition becomes increas-

ingly difficult, more and more urine is habitually retained, and this for several reasons. The more nearly the bladder is emptied, the less efficaciously is it able to contract with force on its contents; and the more the urethral orifice is pushed up by the enlarged gland, the more does urine collect in the lowest part of the bladder behind the prostate. Again, when the enlarged median lobe acts as a valve, occluding the urethral orifice on any attempt at micturition, urination becomes possible only, when, by the distension of the bladder and the traction on its walls, the median lobe is drawn upwards and backwards and removed from the urethral aperture. Even then, as the bladder contracts and empties its contents, the middle lobe again settles down and prevents the complete expulsion of the urine. But as the obstruction to micturition becomes greater, the bladder becomes habitually more and more distended, until finally, being always as full as it will hold, it ceases to act as a reservoir. The urine which flows into it from the ureters constantly dribbles out through the urethra, and permanent incontinence therefore results. In time, a bladder which is thus chronically over-distended loses tone, and becomes paralysed or atonied.

The retention in its turn sets up cystitis, with alkalinity of the urine and the secretion of much sticky, viscid mucus. The urine is often very foul indeed, and in bad cases contains pus and blood derived from the ulcerated bladder-walls. Occasionally, phosphates are deposited in the alkaline urine, and form concretions on the mucous membrane. In other cases definite calculi may be formed.

The effect of the retention of urine and of the hypertrophy of the bladder-walls is **distension of the ureters and of the renal pelves and calices.** Pyelitis and nephritis may also be caused by extension of inflammation from the bladder.

In addition to the chronic retention of some of the urine *in cases of enlarged* prostate, acute and com-

plete retention is liable to result from anything which causes congestion of the prostate and consequent swelling of the gland. Thus, a man who has always been able to pass his water, although with difficulty, may have an attack of acute retention as the result of exposure to cold and wet, or of indulgence in alcoholic liquors. Either of these may cause prostatic congestion and swelling—conditions which are usually temporary and amenable to properly directed treatment.

TUMOURS OF THE PROSTATE.

Innocent tumours of the prostate, which consist of fibrous or glandular tissues and complicate general hypertrophy, have already been described; they are almost the only new growths of an innocent nature that are met with in this gland.

Malignant tumours are usually carcinomata, though sarcomatous growths have been observed. The carcinomata are of the glandular or spheroidal-celled variety, and are more often soft or "medullary" than hard or "scirrhous." They grow rapidly, and tend to cause the same complications as similar tumours arising in the bladder. Not infrequently they cause pressure on, or fungate into, the rectum.

PROSTATIC CALCULI.

The calculi which are of common occurrence in the prostates of old men have nothing to do with urinary calculi. They are developed in the glandular tissue, and form small concretions about the size of grains of barley, and seldom larger. They are commonly multiple, and by their mutual pressure become facetted. In most cases they give rise to no trouble, but in some cause difficulty of micturition, and more rarely suppuration in the prostate. They are composed almost entirely of phosphate of lime, with about 15 per cent. of animal matter.

CHAPTER XLVI.

TUBERCULAR DISEASE OF THE GENITO-URINARY TRACT.

TUBERCULOSIS may affect any part of the genito-urinary tract, and, as it is specially liable to attack many parts in the same patient, it is advisable to treat of the disease as a whole. It may commence in the bladder, kidneys, or testes, and is especially common in young adults.

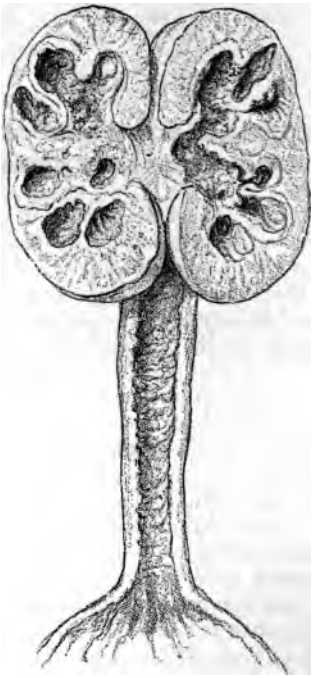
The first morbid change in the **bladder** is the growth of small grey tubercles, such as are commonly seen wherever tuberculosis occurs. These, which are most numerous about the trigone, after a time break down and form circular superficial ulcers without any induration or thickening. By an extension of this process, the mucous lining is destroyed and general cystitis is set up.

In the **ureters** similar changes ensue, and these tubes become ulcerated and roughened; their walls also are usually much thickened. In some cases great obstruction is offered to the passage of urine, and occasionally the ureter is practically obliterated.

In the **kidneys** the pelvis and calices are chiefly affected. Their mucous lining becomes swollen and thickened, and in time ulcerated, forming a soft pulpy membrane like a piece of sodden wash-leather. The discharge from the inflamed surfaces is at first mucoid, but very soon becomes purulent and blood-stained. The course *of the disease* differs much in different

cases. In some, the urine finds difficulty in obtaining an exit on account of the swelling of the soft tissues and obstruction in the ureter, and the pelvis

FIG. 89.

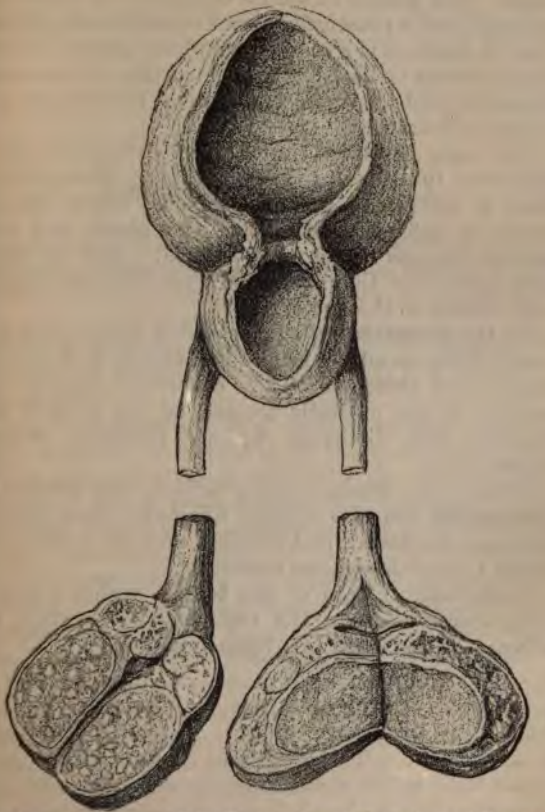


A Tubercular Kidney and Ureter. The kidney shows numerous cavities which were filled with caseous pus. The mucous lining of the ureter is roughened and ulcerated, and the whole tube is much enlarged.

and calices consequently become distended, and the whole kidney greatly enlarged. Suppuration commonly extends to the kidney substance, and in time to the peri-nephritic tissue, causing in the latter situation the

formation of a peri-nephritic abscess. This may come to the surface and burst externally, the patient sub-

FIG. 90.



Tubercular Disease of the Testes, Vasa Deferentia, and Prostate. The testes are studded with numerous caseous nodules, the vasa deferentia are thickened, and the prostate contains a large abscess-cavity.

sequently dying from exhaustion or from destruction of the renal secreting substance. In other cases the

inflammatory process gradually subsides, the exudation diminishes, and many of the products of inflammation undergo caseation, forming a putty-like pultaceous mass. The kidney in such a case loses all functional activity, and is practically placed outside the organism, just as much as is a caseous lymphatic gland. If the other kidney is healthy, and is capable of becoming hypertrophied to a sufficient extent, life may be prolonged indefinitely.

In many patients the disease commences as a deposit of tubercle in the renal cortex. From this, as from a centre, the mischief spreads, other deposits occur in different portions of the gland, and thus several caseous masses are formed. Any of these may burst into the pelvis, and from this the tubercle may extend to the ureter.

In the **prostate,** tubercle causes a general enlargement of the gland, with the formation in it of caseous masses and abscesses. These commonly come to the surface at the prostatic urethra or the neck of the bladder, and discharge by an irregular ragged aperture.

When the prostate is attacked, the **vesiculæ seminales** are also usually affected. They become enlarged, hardened, and nodular, and, on section, are found to contain caseous matter.

Tubercular disease of the **testis,** which is almost always present when the vesiculæ and prostate are affected, is described in a future chapter.

CHAPTER XLVII.

URINARY CALCULI.

THE salts which are normally held in solution in the urine may be deposited from that fluid in the form of concretions or calculi, and may then be retained in any part of the urinary tract.

The most common calculi are those composed of uric acid, of urates, of oxalate of lime, and of fusible phosphates.

Calculi composed of **uric acid** or **urates** are met with chiefly in the children of the poor, and in men of the gouty or uric-acid diathesis. In children they appear to result from feeding with indigestible or improper food, which results in the production of undue quantities of waste matter and excess of work for the excreting organs. The urine consequently becomes highly acid and concentrated, and the solid matter, being more than can be properly held in solution, is deposited as a sediment in the renal tracts.

The ingestion of excessive quantities of food or of alcoholic liquors, combined often with deficient exercise, a torpid liver, an unhealthy skin, and constipated bowels, brings about the same result. More work is thrown on the kidneys than should fall to their share, the urine becomes concentrated, and calculi are formed. It appears probable that mere concentration of urine is not, however, enough in itself to produce calculi, and that the highly acid urine first causes a catarrh of the renal tubes. The crystalline deposit is supposed to be

formed in the renal epithelial cells, and to extend from them to the lumen of the tubes.

Oxaluria, or the presence of **oxalate of lime** in the urine in excessive quantities, can hardly be regarded as having been at present satisfactorily explained. It has been described for many years as occurring in connection with a definite diathesis, the so-called "oxalic-acid diathesis," in patients who are in a broken-down or debilitated state of health, who are overworked or worried, with much nervous depression, &c., but at the present time there are many who think that there is no definite diathesis associated with the formation of oxalate of lime, and consider that its presence in the urine is due to the ingestion or failure of assimilation of vegetables and fruits. Other authors are of opinion that oxalic acid is formed by the decomposition of uric acid, and consider that its production is only a variation or modification of the uric-acid diathesis. Whatever may be the final conclusions, it is certain that oxaluria and oxalate-of-lime calculi are by no means limited to debilitated or broken-down patients, and that oxaluria often alternates with the presence of uric acid and urates in the urine.

RENAL CALCULUS.

Most of the calculi which are formed in the kidneys escape from the gland whilst yet small, and are subsequently voided in the form of gravel. Some, however, remain behind. The effects produced by a renal calculus depend much upon its position and mobility, and to a less extent on its size. If formed and retained in the cortex, it may become encysted and fixed, shut off from the urinary tract, and so give rise to little or no trouble. If, on the other hand, it passes into the pelvis, it is liable, by its constant movement, to cause **pyelitis,** with, in time, hæmaturia and pyuria, whilst, by occasionally blocking the orifice of the ureter, it may bring on attacks of renal colic and

cause distension of the pelvis and calices. The more freely movable it is the more pain it will cause.

The worst, however, that can result from the presence of a calculus in the kidney is the blocking of the ureter by the impaction of the stone. The urine is then retained in the renal pelvis, and **hydronephrosis** results, the calices becoming distended and the glandular tissue being absorbed by pressure.

FIG. 91.

A Suppurating Kidney with a Calculus impacted at the Orifice of the Ureter. The calices are dilated, and the renal tissue atrophied. The kidney was very large, and full of pus.

In many cases the irritation caused by the stone results in suppuration of the pelvis and calices, and pyuria. The pus usually has some difficulty in escaping, on account of inflammatory swelling of the mucous membrane of the pelvis and ureter, and the kidney consequently is distended by it, and becomes *in time a huge multilocular* abscess-cavity, often pro-

ducing a considerable swelling in the lumbar region. When the renal pelvis is distended by pus, the condition is named **pyo-nephrosis.** In cases such as these the suppuration may extend to the neighbouring cellular tissue, and cause the formation of a **perinephritic abscess.** In proportion as one kidney is destroyed the more does its fellow, if healthy, become hypertrophied to supply the needs of the organism, and thus the quantity of urine may not be seriously diminished.

A renal calculus tends to increase in size by the

FIG. 92.

A Kidney with a Large Branched Calculus occupying the Pelvis and Calices.

deposit on its surface of fresh concretions. So long as the urine is acid the increase is chiefly by the deposit of uric acid, urates, or oxalate of lime, but, when as the result of pyelitis the secretion becomes alkaline, phosphates are deposited, not only from the urine, but also from the pus and mucus which are present. As a renal calculus grows it usually becomes branched, and in time the whole of the calices may be filled with calculous material attached to a central stem in the pelvis and ureter.

CALCULI IN THE URETER.

If a calculus is not blocked at the orifice of the

ureter, it is generally able to traverse that tube and to reach the bladder. This, however, is not always the case, and the stone may be impacted in any part of the tube. If it does not stick at the orifice, it is most likely to be arrested at the other extremity of the ureter. The effects of blocking of any part of the ureter are identical with those already described as following impaction of the stone in the renal pelvis, and do not require further description.

VESICAL CALCULI.

Calculi in the bladder most usually result from transit of a stone from the kidney, but, as already

FIG. 93.

Section of a Uric-acid Calculus, showing the smooth outline and concentric laminæ.

stated, stones composed of **phosphates** may be formed *in loco* when the urine has been rendered alkaline by chronic cystitis.

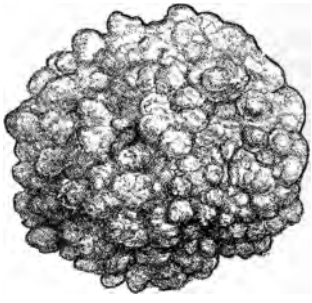
Uric-acid stones are generally round or oval, hard, but brittle. They vary in weight from a few grains to half a pound or more. Their surface is smooth, and, on section, they are of a dull brick-red

colour, with well-marked concentric rings or laminæ. Their central part or nucleus is often darker than the remainder. They are soluble with effervescence in nitric acid, and combustible with very little ash. They are soluble also in a dilute solution of potash.

Urate of soda and **urate of ammonia** often occur in combination. Such stones are smooth, round, or oval, fawn coloured or earthy on section, not laminated, and not so hard as the uric-acid calculi.

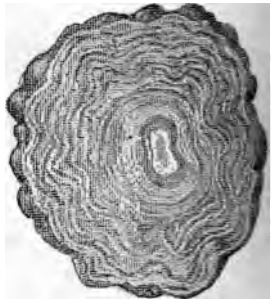
Oxalate-of-lime stones are seldom more than two ounces in weight, and most of them are much below

FIG. 94.



An Oxalate-of-Lime Calculus.

FIG. 95.



Section of an Oxalate-of-Lime Calculus, showing the irregular wavy laminæ.

this. In shape they are usually irregularly rounded with numerous nodular projecting portions, which give them a rough and tuberculated appearance. On section, they are found to be very hard and tough, and of brownish or green colour. They are generally laminated, but the concentric laminæ, instead of being regular and ring-like, as in uric-acid stones, are usually wavy and jagged. Oxalate-of-lime calculi are soluble in hydrochloric acid.

Fusible calculus, or calculus composed of phosphate of lime with phosphate of ammonia and

magnesia, is the commonest form of phosphatic stone, and sometimes attains a great size. It is of a dead-white colour, soft, light, smooth, and not laminated on section.

Other forms of calculi are rare, and do not require separate description. They are composed of xanthic oxide, cystic oxide, phosphate of lime, carbonate of lime, and ammonio-magnesium or triple phosphate.

Many calculi are not composed throughout of the same substance, but are formed of concentric layers of different formation. Thus, it is common to find a uric-acid nucleus surrounded by a ring of phosphates, and this in its turn coated with another layer of uric acid or urates, the whole perhaps surmounted by another phosphatic coat. In other cases oxalate of lime may alternate with uric acid, urates, or phosphates.

The alternation of the phosphatic and uric-acid layers is explained by the differing reactions of the urine. When the latter is acid, the calculus increases in size by the deposit of uric acid; but when cystitis has caused the urine to become alkaline, then the phosphates which are normally held in solution become deposited.

Effects of a stone in the bladder.—A calculus in the bladder always sets up a certain amount of cystitis. To a limited extent the latter is proportionate to the roughness and size of the stone, but it is nevertheless true that in many instances small and perfectly smooth stones cause infinite pain and vesical irritation, whilst in other patients large and rough stones elicit but few symptoms. This is to be attributed to the different idosyncrasies of the patients themselves; children usually suffer more than adults. The changes that occur in cystitis have already been described, but it must be pointed out that the obstruction to micturition caused by the thick and viscid mucus is probably one of the causes of the *hypertrophy of the bladder* which is a common result of a

calculus. This hypertrophy is also probably induced by the occasional obstruction of the urethra by the stone—a circumstance which is most likely to happen at the end of the act of micturition.

In cases of long standing, sacculi may be developed in the hypertrophied viscus. These are of much importance, for in them stones may lodge, or, if lithotrity be performed in a sacculated bladder, great trouble and danger may arise from fragments becoming encysted. The changes that ensue in the ureters and kidneys are such as have already been described under the head of "Surgical Kidney."

CALCULI IN THE URETHRA.

Small calculi are often passed by gouty people who suffer from gravel in the urine, and the large majority of such stones are not retained in any part of the urethra.

The impaction of a calculus is of much more frequent occurrence in children than in adults. The usual place for a stone to lodge is the fossa navicularis, for the very good reason that the meatus is the narrowest point in the whole urethra. Such impaction, indeed, is the most frequent cause of retention of urine in children, and in any case of the kind ought to be at once suspected.

The local effect of the lodgment of a stone in this position is a general œdema of the prepuce, penis, and often of the scrotum, and sometimes urinary extravasation. Although retention is marked, the urethra is often not completely plugged, and the urine consequently may dribble away.

In adults a calculus may lodge behind a stricture. In such cases the urethra usually becomes ulcerated, a perineal abscess forms, bursts externally, and establishes a perineal fistula. In rare and fortunate cases the stone escapes with the pus.

CHAPTER XLVIII.

DISEASES OF THE TESTIS.

MALPOSITION OF THE TESTIS.

The testis may be arrested in any part of its passage from the lumbar region to the scrotum. First, it may never leave this region, but may remain permanently in close proximity to the kidney. Secondly, it may pass as far as the internal abdominal ring, but fail to enter the inguinal canal. Thirdly, it may pass into the inguinal canal, but fail to traverse the external ring. Fourthly, it may pass through the ring, but not descend into the scrotum. The causes of this retention are variously stated. It is probable that the most frequent cause is intra-uterine peritonitis, and the formation of adhesions between the folds of peritoneum in the neighbourhood of the gland, but an unusually small external ring, and a want of power in the gubernaculum testis, have also been shown to bring about an incomplete descent. Shortness of the vas deferens and an unusually large epididymis have also been claimed as causes of retention.

There has been much controversy as to the condition and development of a retained testis, and it is now tolerably clear that, whereas in the majority of cases the testes are undeveloped and the patient sterile, in a few the gland is active, and semen is normally secreted. It is generally considered that the testis is less likely to be undeveloped if retained in the abdomen than if subjected to the pressure of

the muscles by retention in the inguinal canal, and, as might be expected, when the patient is sterile, and especially when virile power is absent, other signs of impaired virility will be found in the condition of the voice, the growth of hair, &c. In all cases of undescended testis the corresponding half of the scrotum as well as the tunica vaginalis is imperfectly developed.

Occasionally, the testis, instead of being retained as above described, descends into unnatural positions, and may thus pass into the perineum or through the crural ring into the femoral canal. I have also seen a case in which, after its transit through the external ring, the gland passed outward into Scarpa's triangle.

Complications of retained or misplaced testis.—A testis which is retained in the inguinal canal is constantly liable to attacks of orchitis caused by the contraction of the abdominal muscles during any violent exertion, and it is by no means uncommon for the gland in such cases to be forced through the external abdominal ring. Such extrusion is merely temporary, and the testis almost at once returns to its previous position. In the perineum also, the gland is greatly exposed to injury, and thus is rendered liable to frequent attacks of orchitis. It must further be remembered that when the testis is retained it is in close proximity to the peritoneum, and that, consequently, inflammation commencing in the testis may extend and cause peritonitis. The gland when retained is liable to be the seat of orchitis in cases of gonorrhœa or of mumps, exactly as it is when in its normal position.

Retention of the testis is generally believed to predispose it to malignant disease in a marked degree, and the explanation that is commonly given is that imperfectly developed organs are more liable than healthy ones to be thus affected, and that the irritation and frequent attacks of orchitis induced by pressure in the inguinal canal are likely to act as

exciting causes. Considering the comparative frequency of undescended testis, I am myself by no means convinced that it is attacked by malignant growth in a larger percentage of cases when in the inguinal canal than when in the scrotum.

Inguinal hernia is a common complication of undescended testis, and generally results from failure in the normal process of closure of the funicular portion of the tunica vaginalis. Mr. Curling and other writers on the subject believe that hernia is much more likely to complicate a late descent of the gland than is its simple retention, for in some patients testes which are retained for months after birth subsequently descend. In such cases the intestine may be found adherent to the testes. Occasionally, hydrocele complicates retention of the testes.

INFLAMMATION OF THE TESTIS—ORCHITIS.

Acute orchitis (as apart from epididymitis) most often results from injury, but is also caused by exposure to cold or wet, and is met with in cases of mumps and in gout, as well as, more rarely, in rheumatic subjects and in patients suffering from acute febrile disorders.

The inflamed testis presents the appearances common to all acute inflammations, but, on account of the denseness of the tunica albuginea, is unable to swell to any extent, and thus becomes proportionately painful. The inflammation rarely terminates in suppuration, the inflammatory products being readily removed by the numerous lymphatics of the part. Abscess and even gangrene have, however, been known to occur. In some cases the orchitis causes so much damage to the glandular epithelium that the testis subsequently becomes completely atrophied.

Chronic orchitis may result from an acute attack which has not undergone complete resolution, but as it is, in simple cases, always combined with some

inflammation of the epididymis, it is not necessary to further describe it here.

EPIDIDYMITIS.

Epididymitis, or inflammation of the epididymis, is almost invariably the result of some irritation or inflammation of the urethra. The epididymis is also commonly affected in orchitis, and amongst the causes of epididymitis may therefore be enumerated those which have already been mentioned in connection with the latter subject.

Inflammation of the urethra, in whatever way excited, is liable to cause epididymitis, and thus the latter may complicate the urethritis caused by gout, the passage of gravel, the use of catheters, &c. Gonorrhœa, however, being the most common cause of urethritis, is also the most common cause of inflammation of the epididymis, and it may further be said that the epididymitis which results from an acute gonorrhœal urethritis is itself likely to be acute, whilst that which arises from a chronic urethritis or gleet is more likely to be chronic.

The epididymitis which results from inflammation of the urethra has commonly been spoken of as "metastatic," a term which implies that the inflammatory process is transferred from the one part to the other; it has also been called "sympathetic." There is every reason to believe that the affection of the epididymis is the result of an extension of the inflammation from the prostatic urethra to the common ejaculatory ducts, and thence along the vasa deferentia. This opinion is borne out by the fact that epididymitis is specially liable to result from inflammations of the deeper portions of the urethra rather than from those of the anterior parts of that tube.

Acute epididymitis is attended with much swelling, which commonly extends to the spermatic cord and the testis; the epididymis is also extremely tender and painful. In these cases, as well as in

acute orchitis, the inflammation frequently extends to the tunica vaginalis, and results in the condition known as "acute hydrocele." This is nothing more than an inflammatory exudation into the cavity of the tunica vaginalis, and is accountable for most of the swelling which is more commonly attributed to the testis itself. In acute epididymitis the scrotum is liable to become red and swollen, and in some cases is greatly enlarged by œdema.

Chronic epididymitis and orchitis may result from an acute attack, or may originate in a chronic inflammation of the urethra. They are perhaps more often dependent upon stricture and its accompanying urethritis than upon any other cause.

In such cases the epididymis becomes enlarged, hard, and knotty, from the formation in it of fibrous tissue developed from the inflammatory exudation. The testis also is swollen and tender, the cord is enlarged, and the tunica vaginalis contains some serous fluid. In cases of long standing the contraction of the newly formed fibrous tissue causes obliteration of the seminal tubules or of the vas itself. Atrophy of the gland also may result, as in acute orchitis. In some cases the inflammation terminates in suppuration, an abscess forms, the skin becomes adherent, and the pus is discharged. Occasionally, after the abscess has burst the testis tends to protrude through the aperture, and the condition known as **"hernia testis"** is produced. This protrusion is generally associated with an unhealthy condition of the gland itself, and is much more common in connection with strumous disease of the testis than with simple chronic orchitis.

STRUMOUS, SCROFULOUS, OR TUBERCULAR DISEASE OF THE TESTIS.

These are the various names applied to a chronic form of orchitis which exhibits in all its phases the *characteristics common* to strumous inflammations.

It has already been mentioned that this affection is frequently an accompaniment of tubercular disease of other portions of the genito-urinary tract, and, as might be expected, it is seen chiefly in unhealthy or strumous subjects, and is more common before than after middle age. There is a great tendency for both testes to be diseased, though one may show symptoms of the affection long before the other is

FIG. 96.

A Tubercular Testis. The epididymis is specially enlarged, and forms a crescent-shaped swelling behind the testis. The tunica vaginalis was distended with fluid.

implicated. Strumous orchitis usually commences as a swelling of the epididymis, and at first causes no pain. The epididymis becomes hard and knotty, and, as it increases in size, forms a semicircular or crescentic mass behind the testis (see fig. 96).

The early extension of the inflammation to the tunica vaginalis is signalized by the formation of a *hydrocele*, which often renders an accurate examina-

tion of the diseased parts more difficult than would otherwise be the case. As the inflammatory process progresses, the swollen epididymis softens at one part, and the superjacent skin becomes red, adherent, and thinned, and finally bursts, giving exit to a few drachms of pus. In the course of the disease the testis also becomes enlarged and nodular, then soft, caseating, or suppurating, fresh abscesses form, and in many cases, through the sinuses which result, a protrusion or hernia of the testicular substance ensues. The spermatic cord, as a whole, is thickened, but the vas deferens is especially hard and swollen. The disease may extend to the vesiculæ seminales, the prostate, or other parts of the genito-urinary tract, but in the majority of patients such a serious extension is not seen, and whilst in many the inflammatory process subsides without ever having arrived at suppuration, in others, after the pus has been discharged, the sinuses slowly heal, and the disease comes to a natural termination.

If the parts themselves be examined at various stages of the process, it will be seen that strumous disease commences in an inflammatory exudation into the connective tissue of the epididymis, combined with a catarrh of the ducts. The inflammatory products evince a great tendency to undergo fatty degeneration, and thus the tubes and connective tissue alike become filled with a caseous pulp. As the process extends to the testis and cord as well as to the skin, those structures also become involved in a similar destruction, and in many instances a little ill-formed pus is produced.

A section of such a testis shows a general enlargement of the gland, with several areas of inflammatory condensation, of caseous matter, or of pus. Towards the epididymis these areas tend to coalesce and unite with the caseous matter, which is here more especially abundant. The tunica vaginalis contains a varying amount of clear straw-coloured fluid, the tunica

albuginea is thickened in patches, the cellular tissue of the spermatic cord is infiltrated and œdematous, and the vas deferens is enlarged to some five or six times its natural size, whilst its lumen is filled with caseous matter.

When an abscess bursts and exposes the interior of a broken-down testis, there is a considerable tendency to extrusion of the latter, together with some of the unhealthy inflammatory or granulation tissue which surrounds and infiltrates it. The protrusion is liable to become increased by the retraction of the skin, and where the cutaneous opening is large, and the skin not closely adherent to the deeper parts, the retraction may result in a complete uncovering of the testis. In such a case the whole gland may be extruded.

A microscopical examination of a strumous testis shows that the process is essentially tubercular, for typical tubercle may be found in all the diseased parts. The epithelium at first proliferates and fills the lumen of the tubes, but is in course of time slowly destroyed by an extension of the tubercular process to the glandular tissue itself. It appears probable that the disease always commences in the intertubular connective tissue, and subsequently extends to the epithelium. Sections of the vas deferens show a similar growth of tubercle in its walls, and in advanced cases partial obliteration of its lumen by a growth of granulation tissue and tubercle. As in the lungs and other parts, the process may spontaneously cease, and the caseous matter either become encapsuled or, in process of time, undergo calcareous changes.

Miliary tubercle of the testis may also be seen in the form of typical grey granulations in cases of general tubercular dissemination, but does not require special description.

SYPHILITIC DISEASE OF THE TESTIS.

The testis may become the seat of syphilitic inflammation at almost any time after the development of

constitutional symptoms. The gland may be the seat of either (1) a diffuse interstitial inflammation, or of (2) one or more gummata.

Interstitial orchitis occurs earlier than the gummatous form, often attacks both testes, and is characterized by a painless swelling of the whole testis, which becomes firm, heavy, of an oval shape, flattened from side to side, smooth on the surface, and not tender. The epididymis is not noticeably affected, and the spermatic cord, although swollen, is not definitely thickened. The tunica vaginalis usually contains an excess of fluid.

On section of such a testis, the tunica albuginea is found to be much thickened, and the fibrous septa which extend from it into the gland appear more prominent and dense than is normal. The gland itself is tough and fibrous and the testicular substance diminished. The fluid in the tunica vaginalis is clear, and in some cases the opposed surfaces of the serous membrane are united by adhesions. A microscopical examination shows a growth in the intertubular connective tissue, at first of leucocytes and of new blood-vessels, afterwards of spindle cells, and finally of fibrous tissue.

The termination of diffuse orchitis differs in different cases. In some, especially those which are not subjected to treatment, the seminal tubes are compressed by the contraction of the dense fibrous growth, and their epithelium, after undergoing fatty changes, is gradually cast off. By a continuation of this process the whole of the gland may be in time destroyed, and the shrinking of the fibrous tissue finally reduces the testis to a small hard mass with no trace of secreting structure. When, however, the disease is treated, the young connective tissue is commonly quickly removed, and the testis again returns to its normal size and function. In some cases portions only of the gland are affected by this *form of interstitial inflammation*, and the changes

above described are then limited to one or more lobules.

Gummatous orchitis.—When syphilitic inflammation attacks the testis in an old or broken-down subject, or when it makes its appearance as a late tertiary symptom, the inflammatory products are liable to caseate and to form gummatous masses. These tend to implicate the tunica albuginea and the tunica vaginalis, to extend to the skin, and finally to burst, giving exit to the blood-stained mixture of cheesy matter and pus characteristic of gummata in other parts, and leaving a circular cavity in the gland. In some cases of gummatous disease of the testis, the opening in the skin becomes the site of a hernia of the testis such as occurs in simple chronic and strumous orchitis.

Section of a gummatous testis usually shows that the gland is the seat of both the diffuse orchitis described above and of the gummatous form. The processes in each are at first alike, and consist of an exudation of leucocytes and a growth of young spindle-celled connective tissue. In the gummatous variety this young tissue breaks down and forms the caseous pulp already alluded to. Gummata in the testis are usually multiple, varying in size from a pea to a chestnut. They are at first firm, yellowish-white, and elastic, often presenting a definite outline and a capsule of fibrous tissue. In their later stages they are caseous or suppurating.

In addition to the above well-recognized forms of syphilitic orchitis, Mr. Jacobson (in his article in Holmes's "System of Surgery") alludes to a chronic inflammation of the epididymis in cases of acquired syphilis, and to gummata in patients who have inherited the disease. Both of these conditions are, however, certainly rare.

CHAPTER XLIX.

TUMOURS OF THE TESTIS.

Tumours of the testis may be either innocent or malignant, but the latter are, unfortunately, by far the most common.

Malignant growths are either sarcomatous or carcinomatous, the sarcomata being more often seen than the carcinomata.

SARCOMA.

Sarcoma of the testis, according to Mr. Butlin, is met with most frequently under the age of ten, or between thirty and forty. Its origin is frequently attributed to injury, and its growth is very rapid. The testis enlarges without pain, but to a great extent maintains its normal shape, and forms a highly elastic swelling, which gives a deceptive sense of fluctuation; normal testicular sensation is often lost. The skin is stretched in proportion to the size of the growth, but very seldom becomes itself implicated. If it does become involved, the tumour subsequently fungates as a bleeding mass, to which the name of "fungus hæmatodes" was formerly given. In the later stages, the spermatic cord is enlarged, and masses of infiltrated glands may be felt in the iliac and lumbar regions. The general health is by this time seriously affected, the patient becomes much emaciated, and dies from implication of the viscera.

An examination of the testis in an early stage shows that the growth commences most commonly in

the posterior portion of the gland, and that the testicular structure itself is often spread over the anterior surface of the tumour. The tunica albuginea at first stretches, but after a time gives way, and may thus allow hæmorrhage to take place into the cavity of the tunica vaginalis. This is an occurrence of some clinical importance, and it is well to remember that hæmatocele may complicate a sarcomatous growth, for in cases in which the diagnosis is difficult the discovery of blood in the tunica vaginalis might otherwise lead to error.

FIG. 97.

Section of a Large Sarcomatous Testis with Hæmatocele of the Tunica Vaginalis.

On section, a sarcomatous testicle is very soft and pulpy, either opaque-white, pinkish, mottled, or gelatinous and semi-transparent; the spermatic cord may be infiltrated with similar growths. The iliac and lumbar glands often form a series of immense tumours, and the liver, kidneys, lungs, and other parts may be infiltrated with numerous secondary masses.

A microscopical examination usually shows a large round-celled growth; but in some cases the cells

are oval or spindle shaped, in others mixed. The round-celled tumours grow the most rapidly, and occasionally involve both testes.

CYSTIC TUMOURS OF THE TESTIS.

New growths of the testis containing cysts are of common occurrence, and, being closely allied to the sarcomata, are best considered in conjunction with them. These tumours appear to originate in the hilum of the testis, and, although all alike as far as

FIG. 98.

Section of a Cystic Sarcoma of the Testis.

the formation of cysts is concerned, differ materially in the formation of their more solid parts. They have lately been investigated by Mr. Eve, and, as his conclusions appear to be more satisfactory than those commonly accepted, I shall venture to quote them. He says that there are three forms—(1) **cystic fibroma,** (2) **cystic myxoma,** (3) **cystic sarcoma.**

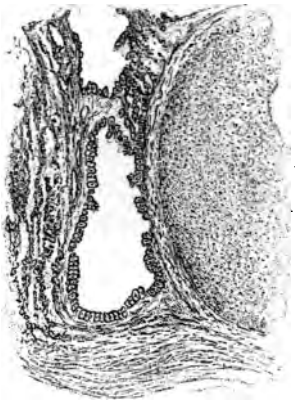
In the first class the stroma is composed of fibrous

tissue, with some admixture of cartilage, and occasionally of unstriped muscle. The cysts are commonly lined with spheroidal or flattened epithelium, but sometimes with columnar cells, which may be ciliated.

The cystic myxomata are composed of mucous and fibrous tissue, with cysts usually lined by columnar epithelium.

In the sarcomatous growths, also, the cysts are

FIG. 99.



Section of a Portion of a Cystic Fibroma of the Testis. One of the cysts, lined by columnar epithelium, lies to the left of a rounded nodule of cartilage. Below and to the left side of the cyst is a stroma of fibrous tissue.

usually lined by columnar epithelium, which here again may be ciliated. Mr. Eve considers that the cystic tumours are developed from the remains of the Wolffian body, and thinks that the cysts also are of new formation; other authors generally are inclined to consider the cysts as developed from a dilatation of the ducts of the rete testis.

It is evident, from a consideration of the great

structural difference displayed by cystic tumours of the testis, that similar difference must be expected in their rapidity of growth and clinical course. Thus, a growth whose stroma is chiefly sarcomatous will develop as a sarcoma in spite of the cysts it contains, whilst the fibrous and myxomatous tumours will not only grow more slowly, but will also run a less malignant course. An examination of the testis in these cases shows a corresponding difference in appearance, the sarcomatous tumours having the characters already described, whilst the fibrous or myxomatous growths display the appearances common to such tissues. The cartilage, when present, is commonly scattered in nodules throughout the section, being sometimes abundant, at other times very scanty. The cysts are commonly small, their usual size being about that of a pea. They contain blood-stained fluid, which is usually viscid, but sometimes thin and serous.

CARCINOMA.

Carcinoma of the testis is almost invariably of the encephaloid variety. Instances of the scirrhous form are very rare indeed, but there is one good specimen of such a growth in the museum of St. Bartholomew's Hospital.

In the rapidity of its growth, its implication of lymphatic glands, and its tendency to affect the viscera, encephaloid cancer does not differ at all from the more malignant forms of sarcoma; the clinical course of the two is indistinguishable, but, whereas sarcoma is sometimes met with in young children, carcinoma occurs only in adult males, commonly over thirty-five years of age. A section of a carcinomatous testis presents the same opaque-white, soft, brain-like mass seen in the most rapidly growing sarcomata, but the mixture of cartilage and myxomatous tissue and the formation of cysts do not occur in the encephaloid cancers.

Microscopical examination shows the usual alveolar

stroma with masses of epithelial cells common to all carcinomata.

INNOCENT TUMOURS.

Innocent tumours of the testis are rare. They comprise enchondromata, fibromata, and dermoid cysts.

Pure **enchondromata** are very uncommon, though, as already described, cartilage may occur in connection with cystic tumours. The cartilage may have either a fibrous or myxomatous basis, but is sometimes purely hyaline. Such tumours grow slowly, and do not tend to affect the lymphatic glands or the viscera.

Fibromata of the testis are still more rare, there being but two or three cases on record.

Dermoid cysts of the testis are more common than either the cartilaginous or fibrous growths. They are of congenital origin, but may subsequently increase in size. The cyst-wall has the structure of true skin, and the cavity contains sebaceous matter, hair, and epithelial scales. In some cases these cysts have been found to contain cartilage, teeth, and bone.

CHAPTER L.

HYDROCELE, HÆMATOCELE, AND VARICOCELE.

A HYDROCELE is a sac containing fluid in connection with the testis or its ducts, but of such sacs there are several varieties.

VAGINAL HYDROCELE.

A vaginal hydrocele, or hydrocele of the tunica vaginalis, is the most common form, and consists of a distension of the tunica vaginalis with fluid. These hydroceles are of very frequent occurrence, and may develop at any age. With respect to their cause there is but little to be said, for, although hydrocele may complicate any of the various forms of chronic orchitis, there is in uncomplicated cases no evidence of any inflammatory origin, the effusion appearing to be simply passive.

The **fluid** of a vaginal hydrocele is of a pale yellow, amber, or straw colour. It is thin and watery, with a neutral reaction, and a specific gravity of from 1020 to 1025. It contains about 6 per cent. of albumen, with a considerable quantity of fibrinogen, but no fibrin ferment, and does not coagulate spontaneously. In cases of long standing the fluid may present a bright and sparkling appearance caused by the presence of cholesterine crystals. In addition to these, the microscope shows merely a few epithelial *cells.*

The **tunica vaginalis** is in most cases simply distended, and shows no structural change, but in patients who have long been the subjects of hydrocele, and especially in those who have frequently been tapped, the serous membrane is liable to become opaque and greatly thickened by a deposit of fibrin on its inner surface and by growth of fibrous tissue in its walls. Sometimes adhesions are formed and partially subdivide the cavity, and occasionally calcareous matter is deposited in the lining membrane. In some cases small fibrous bodies are found loose in the sac, and appear to have originated in the fibrinous exudation which is liable to follow tapping or other injury, thus closely simulating the melon-seed bodies developed in bursæ and ganglia. The hydatid of Morgagni, again, is sometimes enlarged, and attached by a pedicle of considerable length which allows of its free movement. To the irritation produced by this structure the causation of hydrocele is sometimes attributed, but the hydatid is often found pedunculated in the absence of hydrocele, and is not commonly pedunculated when the latter exists. The shape of a vaginal hydrocele is that of a pear with the stalk uppermost; its size varies within the widest limits.

The **testis** is almost always at the posterior and lower part of the sac. It is sometimes a little flattened by pressure, but its structure is not necessarily thereby affected. The connective tissue of the scrotum and cord may be slightly thickened, and the cremaster muscle is frequently hypertrophied to compensate for the extra work it is called on to perform.

Congenital hydrocele and **infantile** hydrocele are simply varieties of the vaginal form in which the funicular portion of the serous membrane is either patent or only partially occluded.

In the congenital variety there is a direct communication between the tunica vaginalis and the peritoneal cavity, and fluid will pass from one to the

other according to the position of the patient or the application of pressure to the scrotum. The communication is in some cases free; in others, the fluid can only with difficulty be squeezed out of the sac drop by drop. Hernia may complicate this condition, but is only exceptionally present.

Infantile hydrocele is the name given to a hydrocele in which the fluid is not confined to the tunica vaginalis proper, but extends a variable distance along an unobliterated funicular portion of the serous cavity. Hydrocele in young children is often of this form: it possesses no special importance.

Inguinal hydrocele is the name applied to a hydrocele of the tunica vaginalis occurring as a complication of an undescended testis, and forming a cystic swelling in the inguinal region.

ENCYSTED HYDROCELE.

An encysted hydrocele is one in which the fluid is contained in a sac separate from that of the tunica vaginalis testis. There are three chief varieties—(1) encysted hydrocele of the epididymis; (2) encysted hydrocele of the testis; (3) encysted hydrocele of the spermatic cord.

Encysted hydrocele of the epididymis is, of these, much the most common. It is usually found in the substance of the upper part of the epididymis, and is often placed between the latter and the testis, the vasa efferentia being spread out over the sac. The fluid is commonly quite colourless, watery, and limpid, containing alkaline carbonates, chloride of sodium, and a mere trace of albumen. Sometimes, on the other hand, the fluid is opalescent or milky, and, on microscopical examination, is found to contain spermatozoa. The cyst-wall is always very thin and delicate, being composed of connective tissue lined with flattened endothelium. The sac is usually globular, and varies in size from that of a hazel-nut to an orange, the latter size being quite exceptional. The

testis lies below and in front. The occasional presence of spermatozoa in these hydroceles has led to much controversy and speculation, but the general opinion appears to be that the cyst itself originates in the remains of fœtal structures which occur in the locality in question—especially the organ of Giraldès and the duct of Müller—and that growing amongst, and pressing upon, the vasa efferentia, it subsequently comes to communicate with one of the latter. Some writers, however, incline to the view that the cysts in question

FIG. 100.

An Encysted Hydrocele of the Epididymis. The testis is below the cyst.

originate in a distended efferent duct, or in the rupture of one of the vasa efferentia and the subsequent formation of a cyst around the extravasated semen.

In addition to the encysted hydroceles above described, small cysts at the caput epididymis are not uncommon. They originate in connection with the hydatid of Morgagni, on the surface and not in the substance of the epididymis, are seldom bigger than *a pea*, contain clear fluid with no spermatozoa, and *never give* rise to any symptoms.

Encysted hydrocele of the testis is extremely rare. It is situated in front of the testis, either between the tunica albuginea and the posterior layer of the tunica vaginalis, or else in the substance of the tunica albuginea itself. This form of encysted hydrocele is believed to originate in an injury which causes hæmorrhage, the extravasated blood being subsequently encysted.

Encysted hydrocele of the spermatic cord is common, and is formed by distension of an unobliterated portion of that part of the tunica vaginalis which lies between the testis and the internal abdominal ring. The fluid is clear and serous, and does not contain spermatozoa. The sac is merely a small portion of peritoneum, and is usually not larger than a walnut. It may occupy any portion of the cord, but is most common just below the external ring. When in the inguinal canal, it may simulate an incomplete hernia.

Diffused hydrocele of the spermatic cord is a misleading name applied to a general infiltration of the cellular tissue of the cord with fluid—a condition for which a better and simpler name is œdema. It is of very rare occurrence.

Hydrocele of a hernial sac is a distension of a hernial sac with fluid secreted by the peritoneum of which the latter is composed. It occurs only when the hernia, as such, has been cured, the aperture of communication between the sac and the peritoneal cavity having been obliterated by adhesions or by omentum.

HÆMATOCELE.

A hæmatocele is a collection of blood either in the cavity of the tunica vaginalis or in a separate cyst in connection with the testis or the spermatic cord.

Vaginal hæmatocele, or hæmatocele of the tunica vaginalis, is by far the most common form, and is generally caused by some injury. In a few

cases, however, no history of traumatism can be obtained, and some writers are of opinion that it is then of inflammatory origin, the blood being supplied by exudation from newly developed vessels which vascularize the products of inflammation formed on the inner surface of the tunica vaginalis. Hæmatocele may also complicate new growths.

Hæmatocele may occur as an uncomplicated condition, but is much more often seen in connection with

FIG. 101.

Section through a Hæmatocele. The cavity of the tunica vaginalis is filled with breaking down clot. The testis, which has been cut open, is quite healthy.

vaginal hydrocele. In the latter case, the effusion of blood may result from tapping, the trocar injuring one of the vessels ramifying over the distended serous membrane, or puncturing the testis. When there is no evidence of either of these mishaps, the hæmorrhage is attributed to the giving way of one of the vessels on the tunica vaginalis as the result of the *sudden* withdrawal of pressure by evacuation of the

hydrocele fluid. Independently of tapping or of hydrocele, a blow may result in effusion of blood and the formation of a hæmatocele.

The **fluid** in hæmatoceles varies much in quality and consistence. When the blood is mixed with hydrocele fluid, the colour is lighter in proportion to the amount of dilution. In recent cases, not complicated by hydrocele, the hæmatocele contains pure blood. The longer the blood remains the more alteration does it undergo, though it is sometimes spontaneously absorbed.

If absorption does not occur, the red corpuscles break up, and their colouring matter becomes diffused, the serum is partially absorbed, and the remaining fluid becomes dark chocolate-brown or black, and sometimes thick and syrupy. The fibrinous constituents of the blood coagulate, and form clots, which, though at first soft and red, after a time become firm and of a yellowish or opaque-white colour. The most firm and fibrinous clot is always next to the serous membrane itself, and the more granular, friable, and darker coagulum is found in the centre of the hæmatocele. The clot is always most abundant on the parietal layer of the serous membrane; and the latter is, in addition, gradually thickened by the formation of fibrous tissue in its walls, to which after many years calcareous matter may be added. The testis is always healthy, though sometimes flattened by pressure.

Hæmatocele of the cord may be either diffused or encysted. The diffused hæmatocele is simply an extravasation of blood in the cellular tissue of the part, and the encysted variety is nothing more than an encysted hydrocele of the cord into which hæmorrhage has occurred. Both are rare.

Encysted hæmatocele of the testis originates in an effusion of blood into an encysted hydrocele of the same part, whilst the name of parenchymatous *hæmatocele has* been applied to effusions of blood in

the substance of the gland itself resulting from injury.

VARICOCELE.

A varicocele is a varicose enlargement of the veins of the pampiniform plexus, and is of exceedingly common occurrence. It originates usually about puberty, and is more frequent in flabby, feeble, and lethargic subjects than in the strong and vigorous.

The frequency with which the spermatic veins are the seat of varicose enlargement is to be explained by their pendulous position, their want of muscular support, their length, and the paucity of valves. Varicocele is more common on the left side than on the right—a clinical fact which is partly accounted for by the somewhat greater length of the left spermatic vein, but is also supposed to be induced by pressure of a loaded sigmoid flexure, and by the fact that the left spermatic vein opens into the renal vein at right angles to the blood-current, whilst the vein on the right side enters the cava obliquely, and empties itself in the direction of the blood-stream.

The affected veins show all the appearances typical of varicosity, being elongated, tortuous, dilated, and pouched. In some cases the distension affects the venules in the hilum testis, and in other cases the disease is complicated by thrombosis or phlebitis.

The testis on the affected side, if one side only be involved, is sometimes softer and a little smaller than its fellow. There is no reason to believe that the pressure of a varicocele ever causes atrophy of the testis, but it is probable that, when the varicose condition appears before puberty, it may interfere with the proper development of the gland.

CHAPTER LI.

DISEASES OF THE FEMALE ORGANS OF GENERATION.

THE VULVA AND VAGINA.

CONGENITAL deformities of these parts are in their slighter degrees by no means uncommon. The **hymen,** instead of being a crescentic fold of membrane, or a diaphragm with a central perforation, sometimes forms a **complete septum** across the vaginal orifice. Until puberty is reached, such a condition often passes unnoticed, but when menstruation commences the menstrual fluids are necessarily retained. If the hymen is slight and frail, it may give way before the pressure of the retained matter; more often, however, it is stretched, and bulged outwards through the labia, forming a cystic swelling, which in some cases, by compressing the urethra, interferes with the passage of urine.

Division of the vagina by a septum into two cavities is a rarer malformation, and is usually associated with a bicornuate or double uterus. Occasionally the vagina is absent, and in most of these cases the uterus and ovaries are also undeveloped.

Hypertrophy of the labia or **clitoris** is in some cases the result of elephantiasis; in others, of chronic œdema or inflammation, but is sometimes apparently idiopathic.

Inflammation of the vagina has already been mentioned in connection with gonorrhœa, and noma vulvæ has been *included in* the chapter on Gangrene.

Vulvar abscesses, however, occur independently of venereal disease, and apparently originate in many cases in the sebaceous glands which are found in this situation. Warty growths and condylomata are generally the result of irritating discharges from the vagina, and though often venereal, are not necessarily so.

Cystic tumours of the labia are sometimes of sebaceous origin, but in other cases originate from contusions or compression during labour. Such cysts come under the head of "hæmatoma," and contain dark, thick blood; they sometimes attain a very considerable size.

Innocent tumours of a more solid nature are usually **soft fibromata.** They grow slowly, are generally pendulous and pedunculated, and so soft as to give to the touch the feeling of fat or fluid.

The most common malignant growth of the labia is **epithelioma,** and in this situation such tumours grow with considerable rapidity. They often extend locally to the bladder or rectum, and cause secondary growths in the inguinal and pelvic glands, and more rarely in the viscera.

TUMOURS OF THE UTERUS.

Fibro-myoma or **uterine fibroid** is the most common new growth of the uterus. There are three chief varieties, named according to their respective relations to the tissues forming the uterine wall—(*a*) sub-peritoneal; (*b*) intramural or interstitial; (*c*) submucous.

The **sub-peritoneal** tumours usually spring from the fundus, and grow—covered only by peritoneum and sometimes by a thin layer of uterine tissue—towards the peritoneal cavity. They are more slow in their growth than the other varieties mentioned, and often cause no symptoms at all. Occasionally, however, they induce slight peritoneal effusion, and may contract adhesions to the intestines, ovaries, &c.

The **intramural** tumours grow in the substance

of the uterine wall, with which the softer varieties appear to be directly continuous, the harder tumours being often completely encapsuled. They often cause considerable hypertrophy of the uterus, induce severe metrorrhagia, and are frequently multiple.

The **submucous** growths extend towards the uterine cavity, and tend to become pendulous or pedunculated. Like the intramural tumours, they cause uterine enlargement and hæmorrhage, and, in addition, by their pressure may cause sloughing of the mucous membrane which covers them. In such cases the growth itself may slough and be cast off.

Fibro-myomata of all kinds appear to owe their origin to anything which causes prolonged congestion or irritation of the uterus, and occur especially in women who have not passed the climacteric. During the involution of the organ after pregnancy, these growths not uncommonly undergo spontaneous absorption. After the menopause, not only do they usually cease to grow, but they also share in the atrophic changes which are in progress in the uterus after this period of life.

Fibro-myomata differ somewhat from one another in their naked-eye appearance, for the more muscular tissue they have, the more soft, red, and fleshy is their cut surface; whilst the more fibrous they are, the whiter and denser are they on section. They are also liable to undergo various degenerative changes. In old people they are always very tough and fibrous, and in many become converted into calcareous masses. Less commonly, cysts are formed in their interiors, and occasionally attain a great size.

On microscopical examination, a fibro-myoma, as its name implies, is found to be composed of a mixture of fibrous tissue and involuntary muscle fibre, these being combined in varying proportions.

Mucous polypi commonly grow from the mucous lining of the cervix or os. They are usually multiple, very vascular, and consist of simple pedunculated out-

growths of the mucous membrane from which they spring.

Malignant tumours of the uterus may be either carcinomata or sarcomata, and of these the former appear to be by far the most common.

Carcinoma may be either of the spheroidal-celled or glandular type, or of the epitheliomatous or squamous-celled variety. The **spheroidal-celled** growths possess the same microscopical structure as similar tumours in other parts of the body. According to the quantity of their fibrous stroma, they are either dense and scirrhous, or soft and medullary. They commonly originate in the cervix, but may spring from the fundus of the uterus. Extending towards the uterine cavity on the one hand, they cause a foul discharge, with much hæmorrhage; and growing towards the peritoneum on the other, they infiltrate the uterine ligaments, extend to the bladder or rectum, and cause fistulous communications, contract adhesions to the abdominal organs, or induce acute peritonitis. They commonly cause glandular infection, and may become disseminated in the viscera. **Epithelioma** is usually described as occurring in two varieties—one originating usually in the mucous lining of the cervix, accompanied by but little warty growth, causing a general infiltration of the uterine tissue, and ulcerating at an early stage; the other commencing at the os uteri, beginning as a papillomatous, warty, or cauliflower growth, and often attaining a considerable size before ulceration begins. In either case extension to the neighbouring viscera, with foul discharge and glandular affection, is the usual sequel.

Sarcomata of the uterus have not been yet sufficiently observed to allow of any general rules being formulated as to their mode of growth or natural history.

TUMOURS OF THE OVARIES.

Ovarian tumours are either cystic or solid, and many of them are cystic with solid growths.

Ovarian cystomata appear to be developed from Graafian vesicles, and in some cases perhaps from corpora lutea. The cysts may be either single or multiple, and in the latter case the septa dividing them from each other are liable to become so thin as to allow of communication between the cavities. The fluid contained in the cysts varies much. It is always albuminous, and in the single cysts is frequently thin, watery, and yellowish. In the multiple cysts it is more likely to be thick and opaque, sometimes acquiring the consistence of glue and a dark-brown colour. It occasionally contains cholesterin.

In the case of multiple cysts there is often solid growth extending into the cystic cavities. Such tumours are named **proliferous cysts.** The solid ingrowth is generally soft and myxomatous, and is itself liable to degenerate and form secondary cysts filled with blood-stained fluid. In rarer instances the solid growth is sarcomatous or carcinomatous. All varieties of cysts are liable to inflame, and to contract adhesions to the abdominal viscera and parietes.

Dermoid cysts are also met with in the ovary. Like similar tumours in other parts, they are liable, after long periods of quiescence, to take on active growth. They contain sebaceous matter, hair, bones, teeth, &c., and sometimes attain considerable size.

Parovarian cysts, or cysts of the broad ligament, are situated in the latter structure, and not in the ovary itself. They are single, contain a clear, watery fluid, and never contain solid ingrowths.

Solid fibrous and malignant tumours of the ovary are also met with, but are not of common occurrence.

CHAPTER LII.

DISEASES OF THE BREAST.

Diseases of the breast are infinitely more common in women than in men, the mammary gland in the latter being in a rudimentary state. It must be understood, therefore, that the following description of diseases of the breast refers, unless the contrary be expressly stated, solely to the female breast.

INFLAMMATION AND ABSCESS.

The hyperæmia and irritation produced by suckling are the most common causes of **acute** inflammation of the breast. Most cases occur either soon after pregnancy or when suckling has been unduly prolonged to some ten or twelve months or more.

In the slighter cases the nipple and areola alone are affected, the skin covering them becoming at first red and swollen, and afterwards eczematous, excoriated, and raw. Cracks or fissures also form, and definite ulcers may be developed. Sometimes the inflammation terminates in the formation of a small superficial abscess in the areola or neighbouring subcutaneous tissue.

In another class of cases the gland tissue itself is involved in the inflammatory process, which appears, in some cases at least, to extend from a cracked and fissured nipple. A single lobule only is at first implicated, and in its substance pus may collect, whilst the rest of the gland remains unaffected. If not

treated, however, by early and free incision, the pus soon makes its way to other lobules, and, before it obtains an exit through the skin, becomes more or less diffused. In consequence of the fascial prolongations of the gland capsule, a single opening now will not suffice to give ready exit to the matter, and incisions have frequently to be made into each of the lobules implicated in the suppuration.

The cellular tissue behind the breast is less frequently the seat of suppuration than the nipple or the gland itself. When pus forms in this situation, it pushes the whole breast forwards and makes its way to the surface at the lower margin of the mamma.

Chronic abscess may also develop in the breast, and, like the more acute inflammation, is generally the sequel of parturition or of a miscarriage. The pus is often surrounded by a considerable amount of fibrous tissue, and, if it be placed in the deeper parts of the gland, may closely simulate a solid growth.

Chronic interstitial mastitis is a form of inflammation of the breast which is seen most commonly in women who have passed the climacteric. It is generally confined to one or two lobules of the gland, and is characterized by the formation of much fibrous tissue, with consequent induration, thickening, and nodulation of the mammary substance. On section, the affected lobules are found to be more white, fibrous, and dense than the remainder of the breast, whilst a microscopical examination shows infiltration with leucocytes, formation of fibrous tissue, fatty degeneration and destruction of the epithelium, and slight dilatation of the ducts and acini in the form of minute cysts. This condition not only simulates scirrhous cancer, but not infrequently is the precursor of a carcinomatous growth.

Paget's disease of the nipple is the name given to a peculiar form of eczema limited to the nipple

and areola, and characterized by its obstinate resistance to all treatment, its tendency to ulcerate, and its liability to be succeeded by the development of carcinoma.

The areola is at first bright red and inflamed, the epithelium subsequently peeling off in branny scales and leaving a raw surface, from which exudes a watery discharge, which tends to dry and form scales. After a time, ulceration succeeds, extending to, and destroying, the nipple in many cases.

The nature of the process has been carefully described by Mr. Butlin; and in seven breasts which I have myself examined I have found very nearly the same conditions that were seen by him.

The process originates in an inflammation of the derma, with small-cell exudation beneath the epithelium. The latter, in its turn, is implicated, its cells being loosened from one another by fluid exudation, and finally cast off. The derma being exposed, the inflammatory process advances more rapidly, and proceeds to the formation of pus and the destruction of the true skin. The inflammation now extends along the ducts, causing their epithelial lining to proliferate, the cells sometimes collecting in masses, which fill the tubes. Following this, there is a tendency for the epithelial cells in the acini or ducts to grow out into the surrounding tissue and to take on cancerous growth, an event which is generally preceded by inflammatory changes in the connective-tissue stroma of the mamma, indicated by exudation of leucocytes and fibrous thickening. The cancerous growth is sometimes directly continuous with the nipple, but is more often quite separate from it and placed deep in the breast. It is usually a spheroidal-celled scirrhous carcinoma, though columnar-celled tumours have been described.

Paget's disease must not be confused with an eczematous condition of the nipple which is sometimes seen as a *sequel* to a cancerous growth, and

which appears to result from some irritating discharge from the ducts.

Hypertrophy of the breasts, in the true sense of the term, is very rare, but cases have been recorded in which the gland has attained many pounds weight, and has, on account of its bulk, required amputation. Most hypertrophied breasts owe much of their size to the presence of numerous fibro-adenomatous tumours.

Galactocele is the name given to a cyst of the breast containing milk. It develops in connection with lactation, and is supposed to originate in rupture of one of the milk-ducts. Such a cyst may contain a pint or more of fluid, which in some cases is entirely absorbed. In other cases the fluid is reduced to a caseous pulp, occasionally gives rise to suppuration, and is discharged together with the pus.

CHAPTER LIII.

TUMOURS OF THE BREAST.

Tumours of the breast are commonly of a mixed nature, containing both connective-tissue and epithelial elements. It is not, therefore, possible to classify them under either the connective-tissue or epithelial new growths. The classification of these tumours is made still more difficult by the fact that they are often complicated by cysts; nevertheless, their structure is generally perfectly clear.

ADENOMA, ADENO-FIBROMA, ADENO-SARCOMA.

These are the names given to a class of mammary tumours which all contain a certain amount of breast tissue embedded in a fibrous or fibro-sarcomatous matrix. The pure **adenoma** is very rare if the name is strictly limited to tumours composed throughout of tissue such as is found in a lobe of the normal mamma. I have seen only two examples amongst a large number of mammary growths. They were yellowish-white in colour, soft, lobulated, and encapsuled, and, on section, showed, under the microscope, numerous ducts and acini embedded in a fibrous matrix. The only point in which their structure differed from that of a normal breast was that the gland tissue was irregular in the manner of its arrangement.

deno-fibromata are the growths which are com-
y spoken of as "chronic mammary tumours,"

FIG. 102.

denoma of the Breast. The tumour does not materially differ from normal breast tissue. (Zeiss, A.)

FIG. 103.

Fibro-adenoma of the Breast. The glandular tissue is adly developed, and is mingled with much fibrous tissue. Zeiss, A.)

ugh this name is used very loosely, and is also ed to many of the adeno-sarcomata as well. The

adeno-fibroma is the commonest of the breast tumours. It is generally single, movable in the mamma, lobulated on the surface, encapsuled, except in its deeper parts, where it is commonly continuous with the surrounding gland; on section, it is found to be firm, white, and fibrous, and to exude a little viscid fluid. Microscopical examination shows a stroma of fibrous tissue, in which, in typical specimens, but few connective-tissue cells are found, mixed with a variable amount of gland tissue. In some cases the gland tissue is exceedingly scanty, not more than one or two acini appearing in a single field of the microscope; in others, as much as a quarter or a third of the growth is composed of glandular elements. The acini and ducts are usually not well formed, the lumen of the tubes, as well as their outline and limiting membrane, being ill defined, and their epithelial cells small and more numerous than natural.

Adeno-sarcomata are not separated by any hard-and-fast line from the adeno-fibromata, there being all grades of intermediate growth. An adeno-sarcoma resembles an adeno-fibroma in its encapsulation and its lobulated surface, but is softer, less fibrous, and more gelatinous on section. Microscopical examination shows a stroma composed of delicate fibrous tissue, containing numerous oval or spindle cells mingled with a good deal of homogeneous mucoid material and a few branched or stellate cells. In the midst of this complex stroma is embedded gland tissue, such as has already been described as occurring in the adeno-fibromata.

CYSTIC ADENO-FIBROMA AND CYSTIC ADENO-SARCOMA.—SERO-CYSTIC TUMOURS.—PROLIFEROUS CYSTS.

In many of the adeno-fibromata and adeno-sarcomata, cysts develop from the mammary acini and ducts. These vary greatly in size in different tumours

and in different parts of the same growth. In many tumours which to the naked eye are apparently not cystic, the microscope shows that here and there throughout the sections the acini and ducts are distended, and form irregular cavities or spaces, in some places elongated and slit-like, at other parts more rounded or oval. In other tumours, cysts of all sizes, some a couple of inches in diameter, are found, filled with serous or mucoid fluid, and containing in most cases a certain amount of solid growth. The cysts are lined by one or more layers of short columnar or spheroidal epithelium, though in many cases where the cavities are large the epithelial lining is very liable

FIG. 104.

Fibro-adenoma of the Breast with Cysts. The cysts are developed from the mammary acini, and are lined by epithelium. (Zeiss, A.)

to separate during the manipulation necessary for the preparation of a microscopical section.

Cystic adeno-fibromata and adeno-sarcomata have long been known as the "sero-cystic tumours of Brodie," and under that heading growths of very different structures have been classified. These tumours are generally of considerable size, and may attain

several pounds in weight. Their surface is bossed, the cysts presenting themselves as rounded swellings of various dimensions. Their consistence is unequal; elastic or fluctuating in some parts, they are solid in others. A section liberates a certain amount of clear or slightly blood-stained serous or mucous fluid, and shows that the tumour as a whole is encapsuled. The solid portions of the growth are either white and

FIG. 105.

Fibro-sarcoma of the Breast with Cysts (Sero-cystic Disease). The cysts are lined by epithelium. The new growth springs from the connective tissue of the mamma, and several processes of it have extended into the cavity of the large central cyst, and partly filled the latter. These intra-cystic growths are covered by the epithelium lining the cyst. (Zeiss, A.)

fibrous, or pinkish, fleshy, soft, mucoid, or gelatinous. The cysts in some cases are chiefly filled with fluid, in others they contain masses of new growth, and are then named "proliferous." The solid growth, however, is not really within the cyst cavity, although to the *naked* eye it may appear to be so. It is simply a part of the new growth, forming the bulk of the tumour,

which has invaginated the cyst wall in front of it, and thrust it into its own cavity. The protruding mass is always covered by the epithelial cells which line the cysts, and does not penetrate or fungate through them.

Microscopical examination shows that in the cystic adeno-fibromata the growths have the same structure as the adeno-fibromata, which are uncomplicated with cysts; similarly, the cystic adeno-sarcomata have that of the adeno-sarcomata without cysts. Many of the so-called "chronic mammary tumours" are simply proliferous cystic tumours on a small scale.

The clinical course run by the tumours above mentioned differs according to their structure. The solid growths, whose structure is chiefly fibrous and glandular—the adeno-fibromata—develop in young women, and are most common between the ages of seventeen and twenty-seven. They grow slowly, and never attain a great bulk, being seldom larger than a walnut. They do not affect the lymphatic glands or implicate the skin, and are generally freely movable in the breast. In most cases they do not cause severe pain, and are not tender, though some few of them are so painful as to have acquired the name of "painful mammary tumours." These do not differ in their structure from the painless growths.

The adeno-sarcomata grow more rapidly than the adeno-fibromata, and attain a greater size. They are softer than the latter, but do not implicate the tissue outside the breast or involve the lymphatic glands. Clinically as well as structurally they are not definitely separated from the more fibrous growths.

The proliferous cystic tumours are generally seen in women somewhat older than those in whom the solid growths usually occur, but, like the latter, their clinical course depends on their structure. If the intra-cystic growths and the stroma of the tumour be fibrous, several years may elapse before the patient applies for relief, and I have seen breasts removed in

which the swelling had existed as long as six or seven years. When, however, the stroma is sarcomatous the rapidity of increase is vastly greater, and is in proportion to the abundance of the cell-growth, and the absence of fully formed fibrous tissue. The breast in bad cases may double its size within six or eight months. The more sarcomatous the tumour, the more likely it is to implicate the skin, which in these cases is destroyed rather by pressure than by infiltration, and allows the protrusion of a bleeding mass which soon ulcerates from exposure, and discharges pus mixed with blood-stained fluid from the cysts.

Before the skin is involved, a breast containing a proliferous cystic growth presents a very irregular outline, the surface being raised so as to form rounded swellings of various sizes which correspond to the cysts above described. A serous blood-stained discharge is often noticed to exude from the nipple, and can be increased by pressure. This results from a communication existing between one of the milk ducts and a cyst containing fluid. However large a size the proliferous growths acquire, they practically never implicate the lymphatic glands, and only a few of the more sarcomatous ones become disseminated.

Fibrous tumours unmixed with any gland tissue are rare, and do not differ materially from the adenofibromata.

Sarcomatous growths, solid throughout, and containing no gland tissue, are more common than the pure fibromata, but are still of comparatively rare occurrence. Round-, oval- and spindle-celled sarcomata have been seen in the breast, and here, as elsewhere, the round-celled growths develop more rapidly and show a greater tendency to disseminate than do the spindle-celled tumours. The axillary glands are very rarely involved.

Cartilaginous and **bony** tumours of the breast are very uncommon, there being only about half a dozen cases on record. In several of these also the

cartilage or bone was merely a part of a growth which was otherwise sarcomatous.

CYSTS.

Cysts of the breast are usually divided into retention cysts and serous cysts.

Retention cysts are formed by distension of the mammary acini and ducts. They may be either single or multiple, but the latter is the more common form. They are frequently seen in elderly women in whom the breasts are undergoing atrophic changes, and are then sometimes called "involution cysts," but they may occur at any period of life. Their size varies much; in some cases they are quite microscopic, in others they contain five or six ounces of fluid. The latter is in some cysts quite clear and watery, in others blood-stained, thick, and viscid. The tension inside the cyst is occasionally so great that when the latter is situated in the deeper parts of the mamma it simulates a solid tumour.

Microscopical examination of different specimens shows all stages of development from the mammary tissue, the cyst-wall being formed of fibrous tissue lined by epithelium, which is either spheroidal or columnar according as the cyst has developed from an acinus or a duct. The larger the cyst the more flattened is its epithelial lining, and the greater tendency is there for the latter either to become quite flat or to be shed. Thus it is common to find cysts which are lined in part by flattened epithelium which in the rest of the circumference is absent.

In some cases **papillary** growths of a bright red colour, like minute raspberries, grow from the cyst-walls. They are composed of a very delicate connective tissue with thin-walled blood-vessels covered by epithelium, and are very liable to bleed.

In cases of cysts containing these papillæ, I have seen considerable discharge of blood-stained fluid from the nipple. They grow especially in those cysts which *are formed by distension* of the ducts. (See Fig. 106.)

Serous cysts of the breast are supposed to be formed by distension of a connective-tissue space or lymph space with serous fluid. There is really no proof that cysts are formed in this way in the breast, and it has never been explained why such cysts should be so common when they are associated with the connective tissue of the mamma, whilst in other parts of the body they are only very rarely found as new formations. I myself am of the opinion that the so-called serous cysts are really formed by the distension of acini,

FIG. 106.

Portion of a Papillomatous Ingrowth from a Duct-papilloma of the Breast. It consists of a delicate stroma of connective tissue covered by columnar epithelial cells. (Zeiss, A.)

and that the failure to find an epithelial lining results either from the cells of the latter having become extremely flattened and like endothelium, or having been shed as already described. My reason for arriving at this conclusion is, that an examination of many cystic breasts has shown me all stages between cysts lined by typical glandular epithelium, and those in which no such lining could be demonstrated.

CARCINOMA.

Spheroidal-celled carcinoma is met with in the *breast in* all its varieties—scirrhous, encephaloid and

colloid, but of these the first is infinitely the most common.

Scirrhous carcinoma is most often observed in women over forty, but is occasionally seen in patients younger than this by some eight or ten years. It usually commences as a hard rounded lump, which is movable and painless—conditions which are very commonly considered to be incompatible with malignancy, but it is therefore all the more necessary to bear them in mind. As the lump increases, it becomes rough, irregular, and nodular, more evidently hard, and less movable. When the tumour approaches the skin, it commonly causes the latter to become dimpled or puckered, and at a later date widely adherent. At

FIG. 107.

Section of a Breast with Scirrhous Carcinoma. The growth infiltrates the fat, and has caused retraction of the nipple. (From a specimen in St. Thomas's Hospital museum.)

the same time, or sooner, the nipple is commonly retracted. The affected skin soon becomes red, shiny, and often œdematous, finally ulcerating at one spot, and allowing the protrusion of a bleeding mass of cancer. The tumour, however, extends not only towards the surface, but also to the deeper parts, infiltrating the pectoral muscles, fixing the breast so that it becomes perfectly immovable, and even extend-

ing down to the ribs themselves. At an early period the lymphatic glands in the axilla become enlarged and hard, the glands above the clavicle following suit as the disease progresses. The masses formed by the cancerous lymphatics sometimes attain a great size, and, by infiltrating the axillary nerves, may cause the patient intense pain. Œdema of the arm is often produced by their pressure on the main vein.

By the time the skin has given way, and the axillary glands are enlarged, the patient's health also fails, emaciation being sometimes very rapid. Death may result from exhaustion caused by pain, and discharge of blood and pus from the ulcerating mass, but it is often the result of other complications. One of the commonest of these is pleurisy, a condition very readily accounted for when we consider that, by the time that the tumour has penetrated the pectoral muscle, but little intervenes between it and the pleura. The latter may be involved either by direct extension of the growth, by infection through the lymphatics, or by secondary deposit. A fatal termination may also result from secondary growths in internal organs. The viscera most commonly affected are the liver and lungs, but I have myself seen cases in which all the viscera in the abdomen and thorax were involved at once. Growths in the bones also are by no means uncommon, and are frequently very insidious, perhaps causing no symptoms of any kind until some slight movement results in a spontaneous fracture.

The above description of the course of a scirrhous cancer applies to most cases, but not to all, and the exceptions demand a brief recognition. Instead of commencing as an isolated, small lump, the tumour may from the beginning affect a large portion of the whole breast, being diffused as it were throughout its substance, and presenting to the touch an ill-defined, indurated swelling. In such cases especially, the skin is liable to be involved over a large area, being at first puckered and lumpy, but afterwards converted into a

brawny mass of leathery consistence, and of a dusky-red tint, which envelops the thorax in a rigid inelastic sheath, which has been compared to a hide or a cuirass.

Atrophic scirrhus is the term applied to a form of hard carcinoma, which occurs in elderly and thin women, and is characterized by the constant tendency of the tumour to shrink and contract rather than to increase in size and fungate. Growths such as this are very chronic, and may last several years without making notable progress. They may, nevertheless, destroy life by causing secondary growths in the viscera.

On section, a scirrhous carcinoma of the breast grates or creaks under the knife. Its cut surface, which has been compared to that of a raw potato or an unripe pear, is concave, greyish or bluish-grey in tint, and marked by irregular white dots and streaks. By a little pressure some of this white matter may be squeezed out, and is found, on microscopical examination, to consist of broken-down epithelial cells. Scraping with a knife generally produces a few drops of dirty opalescent fluid, also containing epithelial cells of all shapes and sizes. The margin of the tumour is very irregular and ill-defined, close examination often showing that, as it implicates the neighbouring fat or gland tissue, portions of the latter are, as it were, surrounded by offshoots from the main growth preparatory to their absorption; small pieces of fat may thus be seen embedded in the growing edge. There is never any trace of a capsule. The retraction of the skin or of the nipple is produced by the contraction of the fibrous stroma of the tumour. The nipple is drawn down by its main ducts becoming involved, and consequently may entirely escape retraction if the tumour is limited to the margin of the mamma. In some cases cystic cavities form in the more central portions of the mass. They result from degenerative changes, and contain a dark blood-stained fluid. More rarely suppuration occurs, and in ex-

ceptional cases there is a considerable collection of pus. Sections of the lymphatic glands, and of other secondary growths, show appearances similar to those presented by the original tumour.

Microscopical examination shows the structure common to all the scirrhous carcinomata. The white masses which can be squeezed out are formed by a catarrh of the ducts, the epithelium from which is unable to escape owing to the pressure of the growth.

DUCT CANCER.

Duct cancer is a form of carcinoma which has been especially described by Cornil and Ranvier. It is much softer than scirrhous carcinoma, and of a pinkish or red tint. Closer examination reveals the presence of minute cysts filled with blood-stained fluid, and some soft solid growth. The microscope shows a fibrous stroma enclosing alveoli of considerable size. These alveoli are identical with the cysts seen by the naked eye, and are lined by columnar epithelium. From their walls papillary processes sprout, formed of a delicate stroma of fibrous tissue enclosing blood-vessels, and covered by columnar epithelium.

Tumours of this nature are but seldom met with. Their clinical course seems to be identical with that of scirrhous cancer.

ENCEPHALOID CANCER.

Encephaloid carcinoma of the breast is decidedly very rare—*i.e.*, if the term be limited, as it ought to be, to soft, brain-like tumours of a dirty-white colour, which readily break down on section. Their growth is very rapid, and their tendency to disseminate great. Such tumours have already been fully described at p. 155.

COLLOID CANCER.

Colloid cancer of the breast is also rare, but not so much so as the encephaloid variety. Its clinical

course is identical with that of the ordinary scirrhous tumours. Its structure has already been described at p. 156.

Tumours of the **male breast** are of rare occurrence. I have seen instances of spindle-celled sarcoma and of scirrhous and encephaloid carcinoma. Adenofibromata are also described, but in all the growths the absence of mammary tissue, and consequently of cysts, is very marked.

CHAPTER LIV.

DISEASES OF THE LIPS, MOUTH, AND SALIVARY GLANDS.

THE congenital deformities of the lips and palate are dealt with in another chapter, and it only remains to mention that in some cases there is an **hypertrophy of the mucous membrane,** causing a protrusion and thickening which may be very unsightly. Slight thickenings are comparatively common in strumous subjects, but, in addition to these, there are other cases in which the hypertrophy is much greater and more definite, and is attributed by Mr. Bryant to overgrowth of the submucous glands. The hypertrophy is usually most marked in the upper lip. Examples of this disease are by no means common.

In other cases of acquired deformity the aperture of the mouth is much narrowed by the contraction of cicatrices, the result of lupus or cancrum oris, and, in older subjects, of epithelioma or rodent ulcer.

Deep cracks and fissures sometimes form in the lower lip, especially in the middle line. At first they are quite superficial, but, if left untreated, they sometimes extend to a considerable depth, and even when healed leave a permanent depression. The fissures which are sometimes seen about the angles of the mouth in children are frequently indicative of congenital syphilis, but they occur also in strumous patients.

Ulcers of the mucous surface of the lips are of *common* occurrence in early life, and are usually due

to errors in diet, leading to dyspepsia. In patients, also, who are seriously ill from any cause, superficial ulcerations and excoriations are commonly seen. More rarely the ulceration extends deeply, and causes considerable destruction of the submucous tissues. It should be remembered that these ulcers are not merely of local origin, but are dependent rather on the constitutional condition of the patient.

Primary syphilitic sores are of sufficiently frequent occurrence on the lips to merit special mention. They are generally said to be most common on the upper lip, and are usually met with in comparatively young patients. They frequently afford excellent examples of the true Hunterian chancre, being raised, definitely circumscribed, with a raw excoriated surface, and a very indurated base. The lymphatic glands are early affected, not only those in the sub-maxillary regions, but those over the ramus of the jaw and in the anterior triangles of the neck being implicated. These glands attain a much greater size, and are much more painful and inflamed than are the inguinal glands in the case of an infecting sore on the penis. The sores in question are generally attributed to contact with another person suffering from some secondary syphilitic ulceration about the lips or tongue, and are followed by the usual evidences of constitutional syphilis.

TUMOURS OF THE LIPS.

Innocent tumours of the lips are not of very common occurrence, but several varieties are to be met with. **Cysts** of the mucous surface are amongst the most common. They are seldom larger than a hazel-nut, and contain a clear viscid fluid; they are formed by retention of the secretion in one of the mucous glands.

Nævoid growths for the most part present no very definite peculiarities which require special mention in this place; they have already been described in the

chapters on Tumours. The lips are, however, common sites for their development, and here more than elsewhere large blood-cysts are apt to form, presenting themselves as purple swellings, rounded in shape, and sometimes attaining considerable size.

Glandular tumours of the lips, of slow growth, lobulated, and yellowish-white on section, have been described by Sir James Paget, under the name of labial glandular tumours; they appear to be of rare occurrence.

Papillomata or warty growths are not common. They present the characters shown by such growths in other situations, being raised, with roughened surfaces covered by thickened epithelium.

Epithelioma is the commonest tumour of the lips, but is infinitely more common on the lower lip than the upper. The subjects of such growths are much more often men than women, and are usually past middle life. The tumour commences, as a rule, at or near the line of junction of the skin with the mucous membrane, and attacks by preference that part of the lower lip which is close to the angle. Its earliest appearance is in the form of a small papule or wart; as this increases in size the superficial and most central part becomes excoriated and sore, and after a time definitely ulcerated. The ulcer, once formed, never attempts to heal, its surface is sloughy and its discharge thin and watery, it presents no appearance of granulations. If the lip beneath the seat of growth be felt between the finger and thumb it will be found that the tumour has not only grown towards the surface, but has also infiltrated the subjacent tissues, and the latter, in consequence, feel firm and indurated. If no treatment be adopted, the growth extends to the neighbouring parts, and may thus implicate the jaw, and extend into the tissues forming the floor of the mouth. Meanwhile, the lymphatic glands have become the seat of secondary growth, which infiltrates and destroys the surrounding tissues, very

soon causing the glands to become fixed, and after a time breaking down and forming a fungating mass, which protrudes through the skin. Death finally ensues from exhaustion induced by the pain, discharge and difficulty in swallowing. If an epithelioma be freely removed in the early stage, such complications may be entirely avoided, and although recurrence is common, it is by no means inevitable, whilst dissemination is decidedly rare.

DISEASES OF THE PALATE.

The soft palate is not often the seat of simple inflammation, except in connection with catarrh of the neighbouring mucous surfaces; follicular ulcers, due to dyspepsia do, however, form on it at the same time that they affect the tongue. The palate, soft or hard, may be attacked by either strumous or syphilitic ulceration, and in each case perforation may result. In some instances there is considerable caries or necrosis of the palatine processes, but such extensive mischief is more common in connection with syphilis than with struma. Perforations of large size are very liable to be permanent, but the smaller apertures not infrequently close.

Tumours of the palate are not very rare. The two chief forms of growth are sarcoma and fibro-adenoma. The sarcomata are usually of the round- or oval-celled variety, of rapid growth, occasionally affecting the glands, and prone to recur after removal. They present as rounded, smooth, highly-elastic swellings, usually limited to one side of the palatine arch, often in part encapsuled, but at other times infiltrating the tissues amongst which they lie. The fibro-adenomata are of much slower growth, and I have seen one which at the end of twelve years was little larger than a walnut. They resemble the sarcomata in their clinical appearance, but are more definitely encapsuled, and do not affect the glands or recur after removal. On section, they closely resemble the so-called "parotid

glandular tumours," being friable, granular, and soft. Microscopically examined they have a fibrous or homogeneous stroma, containing a varying quantity of gland tubes, and irregularly arranged masses of epithelial cells. Epitheliomata and mucous cysts, besides other and more uncommon forms of growth, are also met with on the palate.

DISEASES OF THE TONSILS.

The tonsils are very frequently attacked by inflammations, both acute and chronic. **Simple acute tonsillitis** most often results from exposure to cold. It is usually at first limited to one tonsil, but may afterwards affect that of the opposite side. The inflammation is very liable to end in abscess, and the soft palate, the ary-epiglottic folds and surrounding parts become much congested and œdematous. There is much pain, especially on swallowing, and often a considerable amount of fever with severe constitutional disturbance. Respiration is sometimes rendered a little difficult, but there is never urgent dyspnœa. After the abscess has burst relief is speedily obtained. The patients are most often young adults, and anything that impairs the general health appears to act as a predisposing cause of the affection. Some people are liable to frequent recurrences at intervals of a year or less, and in the opinion of some observers the disease is associated with the rheumatic diathesis.

Chronic tonsillitis is of very common occurrence in children, and is certainly most common in those of a strumous disposition. The consequence of chronic inflammation is an enlargement of the whole gland, with thickening of its mucous surface, and formation of thick, viscid, follicular secretion. Both tonsils are generally affected, and may increase to such a size that they meet in the middle line. Examined after removal they are generally found to be more tough and fibrous than natural, but are sometimes flabby

and pendulous; the surface is deeply pitted. Microscopic examination shows an increase of the fibrous stroma, resulting in obstruction to the gland ducts and consequent retention of secretion and distension of the glandular structure. In chronic tonsillitis there is often inflammation of the neighbouring mucous surfaces, causing thickening of the Eustachian tubes with deafness, and a nasal, unpleasant voice. Respiration is sometimes interfered with to such an extent that the thoracic walls are driven inwards by the atmospheric pressure, and the chest becomes marked by the transverse groove so often seen in rickets.

Ulcerative tonsillitis is specially liable to be produced by exposure to bad smells, such as result from defective drainage, but is also met with in patients who are overworked and debilitated from any cause. The ulcers are multiple, but generally superficial, and heal readily under treatment. The affection of the tonsils in scarlatina is by no means always so trifling, and in some cases sloughing ensues, which may reach a most dangerous extent, and may produce alarming hæmorrhage by opening either the tonsillar arteries themselves, or, more rarely, the internal carotid.

The ulceration of the tonsils in diphtheria is of the same nature as that which always characterizes diphtheritic inflammations, and here also sloughing may occur to a dangerous extent. The affections of the tonsils in secondary syphilis have been already described.

Tumours of the tonsils are not common. Perhaps that most often seen is epithelioma, but sarcomatous growths, fibrous polypi and tumours composed of lymphatic structures also occur.

DISEASES OF THE PHARYNX.

Superficial **inflammation** of the mucous membrane of the pharynx, with enlargement of the lymphoid follicles and the formation of follicular ulcers is tolerably common, and is frequently associated

with abnormal conditions of the nares or tonsils. Inflammation going on to the formation of abscess is more uncommon, and may result either from mechanical injury caused by swallowing bones or other hard structures, or from suppuration commencing outside the pharynx proper. Abscesses having the latter origin are sometimes formed in connection with caries of the cervical vertebræ, and may also result from suppuration in the deep lymphatic glands. In either case the collection of pus readily separates the posterior pharyngeal wall from its loose connections with the muscles covering the front of the spinal column, and points as a **retro-pharyngeal** or **post-pharyngeal** abscess, sometimes giving rise to much dyspnœa and dysphagia.

The pharynx may be the seat of either **strumous** or **syphilitic** ulceration. The former occurs especially in children; the latter, which is more common, in patients of more advanced age, with other evidences of syphilis. In either case the ulceration may be very extensive, and may result in much destruction of tissue; after the destructive process has ceased the trouble is by no means at an end, for during the process of cicatrization the soft palate frequently contracts adhesions to the pharynx, and in bad cases may be so universally attached that the posterior nares become completely shut off from the pharynx. Such results as these are almost limited to the syphilitic variety of ulceration.

Tumours growing from the pharynx itself are rare, and the only varieties worth mentioning are soft fibromata, which are pendulous, and sometimes attain a considerable size. The naso-pharyngeal growths are described in the chapter on Diseases of the Nose.

DISEASES OF THE FLOOR OF THE MOUTH.

The floor of the mouth is not affected by any forms *of inflammation* apart from those which involve the

lips, tonsils, or tongue, but **cysts** in this situation are not uncommon. Some of these are simple mucous cysts, like those which occur on the lips, but others are more deeply seated and considerably larger. One of the most common of the latter is that known by the name of **ranula.** This occurs on one side of the floor of the mouth, pushing the tongue upwards and towards the opposite cheek, and often causing a very considerable protrusion in the sub-maxillary region. When of larger size, a ranula passes more towards the middle line of the mouth, and ceases to present the unilateral appearance above mentioned. When opened, the contents are found to be a thick, tenacious, clear fluid, resembling inspissated saliva; and, indeed, such cysts were formerly supposed to originate in an obstruction to one of the salivary ducts. This origin is no longer credited, for it can often be demonstrated that the ducts are quite free, and it is now supposed that a ranula originates in a dilatation of one of the main ducts of the two pairs of small mucous glands which are found on each side of the frænum linguæ, and are known as the glands of Nuhn and Blandin. The obstruction is probably of inflammatory origin, but may in some cases be mechanical, and due to the presence of foreign bodies. The suggestion that ranula originates in a mucous bursa on the upper surface of the genio-hyo-glossus muscle is negatived by the fact that no such bursa has ever been demonstrated.

Another form of cyst which attains a considerable size in the floor of the mouth is the **dermoid cyst,** which is usually met with in the middle line between the genio-hyo-glossi muscles. Although of congenital origin, such cysts do not usually attain a sufficient size to attract attention before the age of fifteen or twenty, and in some cases the patients are still older when the swelling is first noticed. These cysts may be distinguished from ranulas by their central position, slow growth, and the considerable extent to

which they project between the chin and the hyoid bone. They are probably due to imperfect obliteration of the lingual duct, and their walls are composed of skin containing hairs, sweat glands, and sebaceous glands in more or less abundance. They contain sebaceous matter, and, if they have been inflamed, are very firmly attached to the tissues amongst which they lie. They occasionally suppurate.

In addition to these innocent growths, the floor of the mouth may be the seat of **epithelioma,** which runs the usual course of that disease when met with in the tongue.

DISEASES OF THE SALIVARY GLANDS.

Of the salivary glands, the parotid is by far the most frequently diseased. For this there does not appear to be any sufficient cause, but its exposed position renders it more liable to injury and to the effects of exposure to cold.

Mumps, or **epidemic parotitis,** is an infective inflammation of the parotid, with, in some cases, implication of the other salivary glands. It is most common in young patients, and is accompanied by considerable swelling and pain, with enlargement of the neighbouring lymphatic glands. Suppuration very rarely results, but metastatic orchitis is common, and in females the ovaries or breasts may become inflamed. These complications commonly arise towards the end of the attack. Occasionally, atrophy of one of the testes follows the orchitis.

Inflammation of the parotid occurs with considerable frequency as a complication of pyæmia, septicæmia, and other allied conditions; in such cases suppuration is common.

Salivary fistulæ.—A salivary fistula is a sinus in the cheek communicating with the duct of the parotid gland. It results from a wound implicating the duct or from suppuration. The aperture of the sinus is usually very small, and may be so minute as to be

difficult of detection, except by the escape of saliva. Such fistulæ are often prevented from healing by some obstruction in or around the duct.

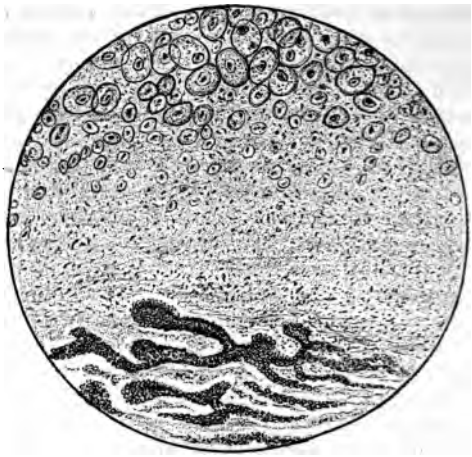
Salivary calculi are concretions of earthy material formed in the duct of one of the salivary glands, being most often found in that of the sub-maxillary gland. They are usually of a dirty-white colour, and have a rough surface. In shape they somewhat resemble a date-stone, being elongated and oval. They are usually very small, but may measure as much as an inch and a half in length. They consist chiefly of phosphate and carbonate of lime combined with a little animal matter; rarely, they are formed around a foreign body. As the result of the obstruction to the escape of saliva, the gland frequently becomes swollen at intervals, the swelling subsiding whenever the retained fluid obtains an exit. The tissues around the obstructed duct usually become indurated after a time, and the duct itself in some few cases has been found dilated into a cystic swelling behind the obstruction.

Tumours of the salivary glands are almost confined to the parotid, being very rare in either the sub-maxillary or sub-lingual glands. The commonest tumour of the parotid is one composed of a mixture of cartilage, myxomatous tissue, and a varying quantity of connective-tissue cells and ill-formed glandular acini. Growths of this nature are often spoken of as "parotid glandular tumours" or "adenomata," but it is quite rare to find a growth the bulk of which is composed of true gland tissue. The cartilage met with in these tumours is of the hyaline variety, and it is by a mucoid degeneration of its stroma and of that of the fibrous tissue of the growth that the myxomatous tissue is produced.

In some cases there is a considerable admixture of sarcomatous tissue; in others, the growth is chiefly cartilaginous; and, as might be expected from this variety in structure, there is a corresponding differ-

ence in the rapidity with which such tumours develop. These growths show no marked preference for either sex, and are of frequent occurrence in adults of middle age; they are not so often seen in children. They grow most commonly in that part of the parotid which overlaps the lower jaw, are usually encapsuled, and, when small, are but little adherent to surrounding parts. If left alone, they may attain a very large

FIG. 108.



Section of a Parotid Tumour. The specimen shows some ill-developed glandular tissue below, myxomatous tissue in the centre, and cartilage in the upper part. (Crouch, $\frac{1}{8}$.)

size, and may cause death by encroaching upon the pharynx or the large vessels in their neighbourhood. They do not affect the lymphatic glands, and, although prone to recur locally after removal, never become disseminated.

In addition to such tumours as these, which are common, the parotid is much more rarely affected

by growths of a more malignant nature. Both sarcomata and carcinomata are met with in this gland, and, although they seldom become disseminated, they are very liable to cause death by pressure upon, or infiltration of, the various structures which lie in their immediate neighbourhood.

The only tumour which occurs in the sub-maxillary gland with sufficient frequency to deserve mention is one composed of cartilage. Even this is very rare, not more than seven or eight cases being on record. Both structurally and clinically they resemble enchondromata in other situations. They are therefore quite innocent.

CHAPTER LV.

DISEASES OF THE TONGUE.

MACROGLOSSIA.

The enlargement of the tongue to which the name of macroglossia has been given is most frequently, but not always, of congenital origin, although in the majority of cases the organ continues its abnormal growth after birth. In this disease the whole tongue, or, rarely, a part of it, is enlarged, and in severe cases protrudes between the lips, or even overhangs the chin. On account of the constant pressure exercised upon the lower jaw, the latter is liable to become deformed, and the development of the teeth to be arrested. By reason of its exposure to injury and irritation, the swollen tongue is very liable to become inflamed, and each attack of glossitis leaves it larger than before. In extreme cases there may be great difficulty in breathing, whilst both speech and deglutition are necessarily much interfered with.

An examination of a tongue affected with this disease shows that the surface is dotted over with small semi-translucent vesicles or papules, which are much more numerous in some cases than in others. The organ is peculiarly shapeless, and may be scarred from old ulcerations, or else marked by the results of more recent inflammation. On section, the tissues are softer than natural, paler in colour, and with a marked absence of healthy muscle. Microscopical

examination shows an increase of soft fibrous tissue, with the formation in parts of a true lymphatic structure such as is met with in the more cortical portions of a lymphatic gland, although of less regular formation. The whole organ is more or less infiltrated with leucocytes according to whether or not it has been the seat of recent inflammation, and its arteries and veins are frequently dilated and thickened. It will thus be seen that in macroglossia there is no true hypertrophy, but rather a general overgrowth and infiltration of the tongue with lymphatic tissue, lymph, and leucocytes, a condition which is generally complicated, and, indeed, to some extent promoted, by frequent attacks of inflammation. On account of this overgrowth of lymphatic tissue, Virchow has proposed the name "lymphangioma cavernosum."

GLOSSITIS.

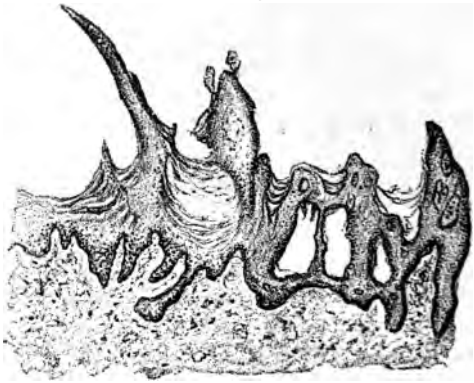
The tongue is liable to be attacked by various forms of inflammation, some of purely local origin, others the result of some constitutional defect; some superficial and non-ulcerative, others ulcerative, and others again affecting the whole substance of the organ.

Superficial glossitis, unattended by ulceration, may be either sub-acute or chronic. It is very commonly of local origin, and may result from any form of irritation—*e.g.*, excessive smoking, scalding by hot liquids, chafing by rough teeth, &c. It is also frequently produced by gastritis or dyspepsia, and is common in connection with chronic alcoholism.

In the **sub-acute** forms, the surface of the tongue is very patchy. In parts it is covered by white fur; in other parts it is raw and glazed, as though the surface epithelium had been removed, and this is, in fact, what has really happened, for in glossitis there is a catarrh, with desquamation of the epithelial covering. The papillæ appear larger than natural, and the organ is painful and tender.

In the more **chronic** forms of glossitis, there is at first a reddening of the inflamed area, which is hidden to a great extent by a thick covering of fur; this is gradually followed by thickening of the surface epithelium and the formation of raised white patches of varying size and shape. In some cases the whole or the greater part of the surface of the tongue is implicated, and the raised patches continue to enlarge by a gradual extension of the inflammatory process to the sur-

FIG. 109.



Section through a Tongue with Chronic Glossitis. The epithelium is greatly thickened, and numerous processes project towards the surface. (Zeiss, A.)

rounding parts. When a patch has been formed, the heaped-up epithelium soon assumes a dirty-white colour, which has caused the application of the term "leucoplakia," whilst, on account of the thickening, the disease has been named "ichthyosis" or "psoriasis linguæ." In many cases the thickening subsides on the removal of the cause, but in other cases it continues, and, the epithelium becoming dry and horny, the surface is soon cracked and fissured. Microscopical examination shows more or less cell infiltra-

tion of an inflammatory nature, with great increase of the corneous layer. In some cases the interpapillary processes of epithelium are much increased in size; in others, they are themselves broken up by cell infiltration. This condition, if allowed to progress unchecked, is liable occasionally to terminate in epithelioma.

The smooth, glazed tongue, which affords another instance of the results of inflammation, is also the product of a chronic superficial glossitis. There is often no apparent cause for the disease, either constitutional or local, and the affection is peculiarly persistent, and obstinate in its resistance to treatment of all kinds. In such cases the surface of the tongue is bright red, perfectly smooth, and shiny, presenting no papillæ, and looking very much as though it had been brushed over with some transparent varnish. This condition usually gives rise to a burning and smarting sensation, and is occasionally accompanied by increased salivation. It affects women as well as men.

In connection with the subject of superficial glossitis, the **rashes** which are met with on the tongue may be briefly mentioned. The commonest of these is a simple white discoloration, which often extends to the gums and mucous surface of the lips; it appears to be commonly caused by smoking, and is very transient. Much less common than this is the **annulus migrans,** or **wandering rash,** which is characterized by the appearance of light-coloured, crescentic or circular bands or patches, spreading eccentrically, rapidly fading in one place, and equally rapidly appearing in another, very prone to persist for months or years in spite of treatment, causing no symptoms of importance, and owning no definite cause. It may occur at any age, and affects both males and females.

Acute parenchymatous glossitis.—This is, fortunately, a rare affection. It may follow injury, such as the biting of the tongue in an epileptic fit,

scalds and burns, stings by insects, &c., or may occur during mercurialism, or in the course of one of the specific fevers. In other cases it is attributed to exposure to cold, or to wounds by dirty and septic instruments.

The disease is characterized by a general swelling of the whole organ. This occurs with much rapidity, and may cause so great an enlargement that the tongue protrudes from the mouth. The surface is livid and shiny except where it is exposed beyond the lips, whilst in advanced cases the lividity may increase till the colour deepens to a blue-black. Suppuration is rare, but in some cases superficial sloughing has occurred. If untreated, the disease may prove fatal by causing dyspnœa, for, not only is the whole tongue swollen, but the ary-epiglottic folds also soon become œdematous. When the inflammation once commences to subside, the organ rapidly diminishes in size.

Abscess of the tongue is rare. It is probably invariably of local origin, and never attains any considerable size. I have seen symmetrical abscesses form on the tongue after an attack of facial erysipelas which extended to the buccal cavity. These abscesses developed without much pain, and there was at no time any material swelling of the whole organ such as is found in typical acute glossitis.

The Syphilitic affections of the tongue have already been described in the chapter on Syphilis.

ULCERATION OF THE TONGUE.

Ulceration of the tongue occurs under several forms, and owns various causes. **Simple,** single ulcers due to irritation of sharp teeth or of rough pipes are most common on the lateral margins. The shape is irregular; the base sometimes sloughy, at other times covered by pus; the edges sharply cut, except when healing is in progress; and the tongue around not indurated. The ulcer is often very painful and tender, and is accompanied by excessive salivation.

Follicular ulcers of the tongue, due to dyspepsia and other allied conditions, are frequently multiple. They are generally not limited to the tongue, but are found also upon the floor of the mouth, the palate, and the lips. The ulcers are superficial, circular, about the size of a split pea or less, and readily heal on the removal of the cause. This form of ulcer is relatively common in young children suffering from teething.

Ulceration of the tongue of a foul and sloughy nature, and associated with similar conditions of the contiguous mucous surfaces, occurs also in connection with mercurial poisoning and with scurvy.

Tubercular ulceration of the tongue has only of late years been brought into notice. Like other tubercular lesions, it is most common in young adults, though cases have been recorded at forty years and upwards. Most commonly there is evidence of tuberculosis of the lungs, either in an active stage or else temporarily quiescent. The tubercular ulcer commences as a little nodule, which soon becomes raw on the surface, and slowly ulcerates; in some cases no nodular thickening precedes the sore. These ulcers are most common at the tip of the tongue or on the dorsum in the middle line. The shape is irregular, the surface sloughy, and the discharge thin and watery; the edges are ragged and undermined, and there is an almost complete absence of induration. When occurring near the tip, there is sometimes an appearance as though the extremity of the tongue had simply been rubbed away and a raw surface produced. Sometimes, under treatment, these ulcers show a tendency to heal, but more commonly this is not the case, and the sore remains open and indolent, neither increasing nor diminishing to a noticeable extent for weeks or months. More rarely the ulcer rapidly extends, and in one severe case, whose progress I watched, the whole of the dorsum of the tongue, the soft palate, the tonsils, and the ary-epiglottic folds *were successively* involved. The lymphatic

glands are not usually affected, but in some cases they become enlarged and inflamed. The prognosis of such cases is bad, chiefly, perhaps, on account of the usual occurrence of tubercle in other parts; but some cases in which early excision has been practised have done well.

In connection with tubercle of the tongue, the occasional occurrence of lupus may be mentioned. It is extremely rare, and requires but brief mention. In the only case I have seen, the ulceration was associated with similar disease of the nose and face.

TUMOURS OF THE TONGUE.

The most common tumour of the tongue is **epithelioma,** and for this reason it is here given the first place. Epithelioma is much more frequently seen in men than in women, and usually occurs after forty years of age. It is often preceded by some form of chronic inflammation, such as simple ulcer due to bad teeth, syphilitic ulcers, chronic superficial glossitis, &c. Considering the frequency with which it follows syphilitic lesions, the greatest care should always be exercised in examining a tongue which has long been the seat of syphilitic disease, for it is quite possible that, although the ulceration is syphilitic, it is also something more, and that epithelioma has been engrafted upon the pre-existing ulceration. Occurring in a tongue not previously ulcerated or inflamed, epithelioma usually commences as a thickening of the surface epithelium in the form of a warty growth, pimple, or nodule. As this nodule increases in size, its most central and superficial part breaks down and forms an ulcer, which is sometimes of very characteristic appearance. In other cases the disease commences as a crack or fissure, which slowly increases in depth, whilst its edges become thick and everted. By far the most common place for an epithelioma is the lateral margin of the tongue, and after that the under surface; but, when attacking the site of a pre-

existing ulceration, it often commences on the dorsum. The epithelial ulcer is of irregular shape, with a sloughy, grey base, and everted edges, which are raised above the surrounding surface and are very hard. If the subjacent tongue be felt between the finger and thumb, it will be found to be much indurated; and, if a section of it be made, it will be seen that this induration is due to the infiltration of the muscle by the new growth. The ulcer, in fact, is an ulcer of a new growth situated on and in the tongue, and it is bounded on all sides, not by lingual tissue, but by the growth itself. It is the presence of this tumour, often raised considerably

FIG. 110.

A Tongue with a large Epithelioma on its Left Lateral Margin. The centre of the growth has ulcerated.

above the surface, with edges overlapping and mushroom-like, that especially characterizes the epithelial ulcer, and when we speak of the indurated edges and base we really are talking of the feel of the tumour itself. If allowed to run its course unchecked, the growth continues to infiltrate the subjacent structures. It gradually extends to the floor of the mouth, and so fixes the tongue that all movement is rendered difficult. It involves the soft palate and the alveolar margins, the maxillary bones, and, passing backwards, it infiltrates the epiglottis or even the larynx itself. As the growth extends, so also does the ulceration; and in some cases the latter progresses quite as rapidly as does the tumour, so that just as fast as the

latter grows, just so quickly does it disintegrate on its surface. In some cases there is much hæmorrhage, and in all there is a bloody discharge, which is often very foul. Salivation is profuse, and pain is constant and severe.

The sub-maxillary **lymphatic glands** are early implicated. At first they are hard and movable; soon they become fixed, and soften in their centres. If examined after removal, they are found to be infiltrated with epithelial new growth, which soon extends from them to the surrounding tissues, so that, in advanced cases, large masses are formed in the neck, extending all round the lower jaw, fixing it so as to greatly limit its movements, and passing down the neck even as far as the clavicle.

The inevitable termination of such cases is a most painful and lingering death, which is due to the exhaustion induced by constant pain and sleeplessness, with inability to eat, and in some cases is accelerated by loss of blood from the ulcerated surface. Very frequently broncho-pneumonia is set up by the passage of the inspired air over the foul surface in the mouth, and in some instances the lungs may be found almost gangrenous. Dissemination is not very common, but I have seen numerous secondary growths in both lungs and in the liver.

If an epithelioma of the tongue be excised, or even if the whole organ be removed, recurrence is unfortunately frequent. It by no means follows that a patient is never permanently freed from the disease, for cases occur in which many years pass by without recurrence, and the patient dies of some other and separate affection. But, speaking of epitheliomata as a class, it must be confessed that those of the tongue are more malignant than similar growths occurring in most other parts. Thus, they grow much more rapidly, ulcerate more quickly, and affect the lymphatic glands much sooner than do epithelio-

mata of the lip, and are, in addition, more prone to recur and to disseminate. It may be that this clinical history depends in part on the favourable conditions for growth, namely, the constant, even temperature and moisture of the mouth; but these are probably only of secondary importance, for it must always be remembered that tumours growing under precisely similar conditions vary much in their individual malignancy according to the tissue or organ in which they originate.

Malignant tumours of the tongue other than epitheliomata are very rare, and need only to be mentioned. The other varieties of carcinoma are practically unknown, and but a few cases of sarcoma are on record.

Innocent tumours of the tongue are also comparatively uncommon, and perhaps that one which is most often seen is **nævus.** This, like similar growths elsewhere, is usually noticed soon after birth, and may either continue to grow, or, after remaining stationary for a time, may slowly wither and disappear. On account of the thinness of their covering, and their liability to injury by hard substances during the act of mastication, nævi of the tongue are rather liable to bleed, and occasionally do so to a dangerous extent. In rare instances they attain such a size as to seriously interfere with deglutition and speech.

Cysts of the tongue containing a mucoid fluid, and due to the distension of a mucous follicle, are occasionally seen. They are seldom larger than a pea, but may attain a greater size.

Papillomata of the tongue are found on all parts of its dorsum. They may be seen at all ages, and are sometimes congenital. They occur as small raised growths, tending to be pedunculated, with roughened surfaces covered by thickened epithelium, not ulcerated, and not infiltrating the substance of the organ.

They consist of an overgrowth of the connective tissue which underlies the epithelium, and are covered by an abnormally thick layer of the latter.

Amongst other and still rarer growths **fatty** tumours and soft **fibromata** may be mentioned. They usually occur in the substance of the tongue itself, but cases are on record in which the fibrous growths have been pedunculated. Enchondromata and hydatid cysts have also been found in the tongue.

CHAPTER LVI.

DISEASES OF THE NOSE.

Lipoma nasi.—The only noteworthy disease peculiar to the cutaneous surface of the nose is the so-called "lipoma nasi." The growth to which this name has been applied is not, however, composed of fat. It results from acne rosacea, and consists chiefly of greatly enlarged sebaceous follicles, with thickening of the true skin by fibrous tissue of inflammatory origin. The growth is most common near the tip of the nose. It is usually lobulated and firm, and in some cases the lobules are pedunculated. Growths of this nature are most common in people of intemperate habits.

Deviation of the septum nasi, and partial displacement of the nasal cartilages, are generally of traumatic origin, but in many cases tend to increase. Occasionally, the bulging of the deviated septum causes so great a prominence in one nostril that it may be mistaken for a polypoid growth.

Simple catarrhal inflammation of the mucous lining of the nostrils is quite the commonest of the affections to which these passages are liable. The most common cause of acute catarrh or coryza is exposure to cold, and the changes seen in the mucous membrane are such as are typical of similar affections of other mucous surfaces.

Chronic coryza is in some cases dependent upon the presence of foreign bodies introduced from with-

out, or of nasal calculi or tumours. In other instances it is dependent on scrofula or syphilis, and more rarely on gout. The scrofulous catarrh is most common in children, and often results in much permanent thickening of the mucous membrane, with partial obstruction to respiration. In the cases dependent on syphilis the discharge is usually profuse and purulent, often foul smelling, and accompanied by ulceration; but all cases are not so severe.

Purulent catarrh, or ozæna.—The term ozæna is used to designate a condition in which there is a discharge of pus from the nostrils accompanied by a peculiarly foul odour. The discharge is often bloody, and may be mucoid rather than purulent; in all cases it is fetid.

Ozæna results from various forms of ulceration, and may be of traumatic, scrofulous, or syphilitic origin. Scrofulous ulceration is most common in children, and especially in those who exhibit some other signs of struma. The ulcers are small, but multiple, are usually covered by a scab, and secrete the thin watery pus characteristic of scrofulous inflammations in other parts. In some cases the ulcers are of a lupoid nature. Syphilitic ulcers are sometimes seen in the subjects of congenital syphilis, but are usually met with in adults; they also are multiple, and may be either superficial or deep. The ulcers are larger and less numerous than those of scrofulous origin.

In both syphilitic and scrofulous ulceration the subjacent bone may be diseased, and either caries or necrosis may complicate the case. In some instances there is extensive destruction of the osseous framework—a condition which is most common in syphilitic patients. In cases of ozæna following injury, it will generally be found that there is some necrosis, and it is to the presence of the dead bone that the continuance of the discharge is to be attributed. In other cases the ozæna is dependent upon the introduction and

retention of foreign bodies, or on the presence of nasal calculi. These latter bodies, called also **rhinolithes,** are most commonly found in the inferior meatus, and are often formed around a foreign body. They consist chiefly of phosphates and carbonates of lime and magnesia.

TUMOURS OF THE NOSTRILS.

The commonest tumours of the nostrils are **mucous polypi.** These growths occur for the most part in young adults, and in some cases follow chronic coryza. They are almost invariably multiple and pedunculated, and vary in size from a pea to a raisin. In colour they are pink or red, and have a translucent appearance. Their surface is very smooth and slippery, and their consistence soft and elastic. Microscopically examined, they are found to be composed of myxomatous tissue, or of very soft and succulent fibrous tissue, in the meshes of which there is a mucoid fluid; they are covered by ciliated epithelium such as is normally met with in the nares. After long exposure near the nasal orifices, the most dependent parts of these growths become more firm, fibrous, and white. The common situation for these growths is the external wall of the nostril, where they are commonly attached to the middle turbinate bone, but they are also found on the superior and inferior turbinate bones, as well as on the mucous membrane covering the roof of the nose; they are very rarely attached to the septum nasi.

The irritation caused by the presence of these growths usually sets up a nasal catarrh, which, in its turn, probably promotes the growth of polypi, for there can be no doubt that the longer polypi are left untreated the more numerous do they become. The smaller and more recent ones occupy the upper parts of the nasal cavities, and do not develop or come into view until the older and more superficial ones have been removed. In all cases polypi cause

an unpleasant nasal intonation of the voice, and, when numerous and large, may cause bulging and deformity of the nose. However large they grow, or however long they remain, they scarcely ever bleed.

Fibrous and sarcomatous polypi.—These growths are not so common as are the mucous polypi; they tend to grow especially from the roof of the nose and the septum. They occur at all ages, but are, perhaps, more common in the young. They usually originate in the periosteum, and not in the mucous membrane, as do the simple myxomata. They vary in size, but often grow so large that the nostril is no longer able to contain them, and they protrude into the pharynx; when occupying this position, they are known as naso-pharyngeal polypi. Their surface is in some case smooth, but in others papillated or spongy. On microscopical examination, they are found to consist either of simple fibrous tissue or else of a fibrous matrix containing connective-tissue cells of various shapes. In some cases the whole growth is sarcomatous, and composed entirely of cells.

Growths such as these grow more quickly than do mucous polypi, but those composed of pure fibrous tissue increase more slowly than the pure sarcomata. As they develop, they tend to extend into neighbouring cavities, and sometimes infiltrate the surrounding tissues, as do malignant growths elsewhere. They may thus produce considerable deformity. Hæmorrhage is a common symptom, and may be very excessive. If removed, all growths of this class show a great tendency to recur, and although this is most marked in the tumours of sarcomatous structure, it is seen also in those composed of simple fibrous tissue.

Tumours of the nostrils other than those above described are of rare occurrence, but epitheliomata, osteomata, and enchondromata growing from the nasal cartilages have occasionally been observed.

CHAPTER LVII.

DISEASES OF THE ŒSOPHAGUS.

The œsophagus is very rarely the seat of simple inflammation or ulceration. Either of these conditions may, however, be set up by injury caused by swallowing rough or sharp substances, or else by drinking caustic acids or alkalies. In diphtheria, also, the ulceration and formation of membrane frequently extend to the œsophagus.

Slight inflammations or ulcerations clear up without inducing any important change, but in some cases of poisoning by corrosive liquids the scarring which ensues is sufficient to cause a diminution in the calibre of the tube, and so produce a **fibrous stricture.**

These, like strictures of other mucous passages, are very liable to continue to contract, and sometimes cause such narrowing that the passage of food becomes impossible, and death from starvation ensues. In cases such as these, the œsophagus above the strictured portion is usually dilated and its walls often thickened. This condition readily explains the fact that food is sometimes apparently swallowed, and is after a time regurgitated, having merely gone as far as the pouch above the stricture. In other cases, again, the mucous lining of the pouched portion is inflamed or ulcerated, with the resulting discharge of much mucus, which is constantly being "hawked up" by the patient.

Cancerous stricture is unfortunately much more frequent than simple fibrous narrowing, and is espe-

cially liable to occur in old people. It is more often met with in men than in women. The most common variety of malignant growth of the œsophagus is certainly epithelioma, but scirrhous carcinoma is by no means rare, and I have myself seen four or five instances of it. Colloid and medullary cancers are much more uncommon.

Epithelioma is especially frequent in the upper part of the œsophagus, and is met with just behind the cricoid cartilage more often than in any other situation. In some cases the new growth extends into the lumen of the tube, and thus obstructs the passage of food, but more frequently it infiltrates the walls in their whole circumference, and, gradually causing an induration and shrinking of the latter, results in the formation of an "annular stricture." In other instances, again, the growth extends along several inches of the tube, and so causes a "tubular stricture." In any case the mucous membrane soon becomes ulcerated, and a foul, sloughing, and bleeding surface is produced. The other most common sites for epithelioma are the lower portion of the œsophagus just above the cardiac orifice of the stomach, and that part of the tube opposite to the bifurcation of the trachea.

Scirrhous carcinoma is not so common in the upper part of the œsophagus as lower down, and is more often seen in that part of the tube which is within the thorax than that which is in the neck. The growth presents the characteristic appearance of similar growths elsewhere, being extremely hard, causing much contraction, and developing with comparative slowness.

Both epithelioma and scirrhus of the œsophagus terminate fatally, and each in much the same manner. Death may be finally brought about in one of several ways. In some cases the inability to swallow induces starvation, but in many more the growth extends to, and opens, the trachea or bronchi, sets up septic

broncho-pneumonia by the passage of the foul discharge into the air-passages, and sometimes leads to an almost gangrenous condition of the lung. More rarely the pericardium is involved, and acute pericarditis terminates the case. In other patients, again, death appears to result rather from blood-poisoning than anything else, and the source of this is not difficult to find when we consider the extremely foul surface from which discharge is constantly passing into the food-passages or is being directly absorbed by the lymphatics.

If a patient who has died of cancer of the œsophagus be examined post-mortem, it is by no means infrequent to find no glandular enlargement and no secondary growths; but in other cases, the glands in the neck or the thorax are infiltrated, and in some the liver, kidneys, or lungs are similarly affected.

Sarcomatous tumours of the œsophagus are very rare, and do not require any special description.

CHAPTER LVIII.

HERNIA.

A HERNIA is an abnormal protrusion of some of the contents of the abdominal cavity. This protrusion most often occurs at one of the places where the passage of various structures from the abdomen to the lower extremities or genital regions provides apertures which may allow, in addition, the transit of some of the abdominal viscera.

A hernia is described as being composed of a **sac** and **contents.** The **sac** consists of peritoneum, and, except in the case of congenital malformations, is formed by a protrusion of a portion of the parietal peritoneum in front of the viscus which is escaping from the abdomen. At first this sac has no independent existence, *i.e.*, if the contents are returned into the peritoneal cavity, the bulging peritoneum will again become smoothed out. This, however, is only in the very earliest stages of the hernia, for after a short time the sac contracts adhesions to the tissues amongst which it has been thrust, and can no longer be reduced. And not only does the sac become adherent to the tissues around it, but the folds into which the peritoneum is thrown at the orifice through which it is extruded become adherent to one another; for it is evident that, if the peritoneum covering the internal abdominal ring, for example, be thrust down into the scrotum, it will be thrown into numerous folds where it passes through the ring, and it is

between these folds that adhesions shortly form. This narrowed part of the sac which lies close to the abdominal cavity is named the **neck,** whilst the lower part, which is much more capacious, is called the **fundus.** The sac thus becomes somewhat flask-shaped, and the neck is in time still further narrowed.

FIG. 111.

The Sac of an Inguinal Hernia, showing the constriction and fibrous ring at the neck.

For, as the result of the pressure of its contents within, and of the abdominal rings without, the peritoneum and sub-peritoneal tissues become matted and thickened by fibrous tissue, and a more or less dense fibrous ring, with occasionally some unstriped muscle, is formed at the neck. The peritoneum forming the fundus also undergoes a change of texture. In most herniæ (*e.g.*, inguinal and femoral) it becomes slightly thickened; whilst in others, notably in the umbilical variety, the peritoneum forming the sac is so thinned that in places it entirely disappears, and the sac is then called "incomplete." In other herniæ, again, the sac is incomplete from the first, for a viscus which is not entirely covered by peritoneum, such as the bladder, or in some cases the cæcum, may escape from the abdominal cavity without pushing a complete

covering of peritoneum i n front of it. In such herniæ the protruded viscera rapidly become adherent to the tissues amongst which they lie, and are consequently irreducible.

The **contents** of a hernial sac consist of a little fluid secreted by the serous surface, with, usually, either intestine or omentum; but almost any of the abdominal viscera may herniate, those only being excepted, which, like the pancreas, are firmly fixed. A hernia containing omentum is named an **epiplocele**; one containing intestine, an **enterocele.**

The **condition of the contents** varies. When the latter can be returned within the peritoneal cavity, the hernia is said to be **reducible,** whilst if such is not the case it is called **irreducible.** In some cases, usually as the result of injury, the hernia becomes **inflamed**; and in others, fæces, accumulating in the gut which is in the sac, cause the hernia to increase in size and to become for the time irreducible —a condition to which the term **obstructed** or **incarcerated** is applied.

Lastly, the hernia may be **strangulated,** but before describing this it is necessary to say a few words on the subject of irreducible herniæ.

As already mentioned, some herniæ are irreducible from the time of their formation, a circumstance which is dependent on the incompleteness of their sac; whilst others, which are at first reducible, become irreducible through the thinning away of the peritoneum forming the sac, and the subsequent adhesion of the contents to the tissues with which they are thus brought into contact. The commonest cause of irreducibility, however, is thickening of the protruded omentum, for, on account of the friction and pressure to which a herniated piece of omentum is subjected, it soon becomes greatly indurated and increased in size by the formation in it of fibrous tissue, and is consequently after a time unable to return by the aperture *through* which it formerly escaped. In other cases,

again, this thickening is accompanied by the contraction of adhesions to the sac-wall or to some of the contained intestine, and thus a further obstacle is offered to reduction. Lastly, it has been already mentioned that, when the intestine in a hernial sac becomes blocked by fæces, it is for the time irreducible.

FIG. 112.

A Hernial Sac, containing a mass of thickened omentum which has become adherent to the posterior wall of the sac.

In a **strangulated** hernia, not only are the contents irreducible, but they are so tightly constricted that the *circulation of the blood through them is interfered with;* it is to the latter condition that by far the greater importance is to be attached. In some cases, and especially those where the hernia is suddenly caused by exertion or injury, the contents, as soon as extruded, are so tightly gripped by the margins of the aperture through which they are thrust that strangulation at once ensues. This is by no means a common occurrence, and it is usually only after existing for some time that herniæ become strangulated. *At first sight* this is not altogether easy

of explanation, for it does not appear evident why a hernia which has frequently descended before, and has always hitherto been reducible, should suddenly become so tightly gripped as to cause its irreducibility and constriction. And it may be easily seen that these conditions cannot be due to any sudden alteration in the size of the rings or the neck of the sac, for neither of these possesses the requisite amount of contractility. The true cause of the strangulation is probably to be found in the descent of a greater quantity of intestine or omentum than has before descended, and the consequently greater pressure to which either is subjected at the aperture through which it passes. This is borne out by the evidence of patients, who often state that on the occasion of strangulation the hernia has descended in greater bulk than previously. The descent may be due either to exertion or to excessive movement of the intestines, as in colic or diarrhœa.

The position of the constriction relative to the contents of the sac differs in different cases. In some it is outside the sac—*e.g.*, at the external or internal abdominal rings, at Hey's or Gimbernat's ligaments, &c. In others it is the fibrous thickening already described as forming the neck of the sac which is the constricting element; whilst in a few and rare instances the coils of intestine are encircled by bands of adhesion formed within the sac itself, in the manner already mentioned in connection with irreducible herniæ.

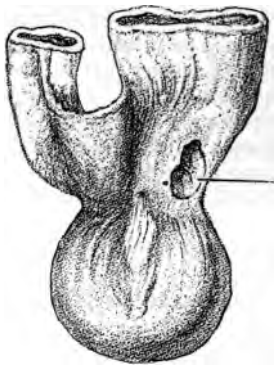
If intestine be strangulated, it is the passage of venous blood which is first interfered with, and the gut becomes congested. The congestion in its turn causes swelling, and thus increases the tightness of the constriction. The gut becomes of a dark plum colour, very tense and shiny, and at the same time the fluid in the sac quickly increases in quantity and becomes blood-stained, being exuded from the serous surface of the imprisoned intestine. In many cases the distended vessels relieve themselves by rupturing into the cavity

of the gut, the blood being subsequently passed *per anum* if the strangulation be relieved. After a time, not only is the venous circulation obstructed, but, as the tightness of the constriction increases, the flow of blood through the arteries is arrested, and gangrene of the imprisoned intestine shortly ensues. In such a case, the colour of the gut changes to an ashen grey, the surface becomes wrinkled, its shiny appearance is lost, and the peritoneum can be peeled off; finally, rupture results, and fæces escape into the sac. Usually, the patient dies by the time such a stage has been reached, death being due to exhaustion and collapse resulting from the pain and vomiting which accompany strangulation. In very rare instances the patient survives yet longer, and, if such be the case, suppuration and sloughing of the sac and of the tissues around it will follow, and fæces will finally be discharged through the skin. In some cases peritonitis supervenes, being caused by an extension of inflammation from the sac; but in other cases, even when gangrene ensues, the extravasation of fæces into the peritoneal cavity, and the spread of inflammation to the serous membrane, are arrested by adhesion between the strangulated gut and the neck of the sac.

But not only does the constriction of the gut tend to cause sloughing of the part beyond the stricture; it also causes ulceration of the intestine at the seat of stricture itself. This is a fact of the greatest practical importance, for it may happen that the state of the knuckle of intestine which is found in the sac during the operation of herniotomy is sufficiently good, and free from appearance of sloughing to warrant its return after division of the stricture, but that, nevertheless, the intestine *where gripped* is at one small spot already ulcerated or sloughing. If this condition is not ascertained by drawing down the gut and examining it before effecting its reduction, nothing can prevent subsequent fæcal extravasation and diffuse peritonitis. (See Fig. 113.)

In cases where an opportunity is afforded of making a post-mortem examination of a case of strangulated hernia which has not been relieved by operation, the difference in the appearance of the intestine above and below the seat of strangulation is very marked, for the coils above are greatly distended and congested, and in extreme cases, where the distension has been excessive, the peritoneal coat splits; the coils below the stricture are, on the contrary, collapsed and pale.

FIG. 113.



Loop of Intestine from a case of Strangulated Femoral Hernia. A small oval ulcer marks the place where the gut has been constricted by Gimbernat's ligament. The large piece of intestine to the right is a portion of the dilated intestine above the seat of strangulation; the small piece of intestine to the left was below the stricture.

In those cases where the gut has sloughed and all the fæces continue to be discharged through the skin, the patient is said to have an **artificial anus.** When most of the fæces are passed by the anus and but little fæcal matter escapes by the opening, the term **fæcal fistula** is employed. If only a small portion of the whole circumference of the gut has been destroyed, such an opening may gradually contract and finally close, but when the sloughing has

been of greater extent so fortunate a conclusion is not to be expected. In consequence of the pressure exercised by the abdominal contents on the distal portions of the intestine, the latter remains collapsed and does not permit of the passage of fæces, whilst, after a time, a further obstacle is interposed in the form of a protrusion of a fold or spur of mucous membrane from between the apertures of the upper and lower pieces of intestine. This acts as a valve, and effectually prevents the passage of fæces by the natural channel, and, until it has been removed by operation, the artificial anus remains patent.

The causes of herniæ are either congenital or acquired. Of the former, the chief predisposing cause is a failure of the normal process of closure of the processes of peritoneum which in fœtal life extend into the scrotum and through the umbilical aperture. The consequent weakness of the abdominal wall is in some instances supplemented by an undue length of the mesentery, which allows the intestines to hang more heavily than is natural against the parietes. In a considerable percentage of such cases, the hernial tendency appears to be hereditary.

In later life the mesentery and omentum may acquire an undue length through stretching, consequent upon the accumulation of fat in their substance, and, from the same cause, the tension of the abdominal contents may be considerably increased. It is thus that umbilical herniæ, more especially, are found in people over middle age who have recently become obese. The reverse condition also, namely, wasting and loss of flesh, tends to the development of herniæ, although in a different manner. Here, the abdominal contents become prone to extrusion on account of the removal of the fat and cellular tissue which normally occupy the apertures of exit from the abdomen. It will therefore be seen that both emaciation and obesity are causes of herniæ in adult life, *and it may be added that* anything which induces

a loss of muscular tone, any condition of debility, is favourable to the production of a hernia. For, normally, the muscular walls of the abdomen by their constant contraction both support the contained viscera and promote the closure of all apertures which naturally exist.

As directly exciting causes of herniæ may be mentioned wounds and lacerations of the abdominal walls. Thus, it is common for a hernial protrusion to follow the operations of ligature of the iliac vessels, abdominal section, &c., as well as accidental injuries of various kinds. Suppuration also tends to produce the same result.

VARIETIES OF HERNIÆ.

It is not possible to devote sufficient space in the present work to a description of the anatomy of the parts concerned in the various forms of herniæ; for such details, works on anatomy should be consulted. It is, however, desirable to point out very briefly the common positions of hernial protrusions, as well as the main points worthy of notice in connection with the probable seat of strangulation and the mode of formation of the sac.

In **inguinal** hernia, the protrusion passes either through the whole length of the inguinal canal (an oblique hernia) or directly through the external abdominal ring (a direct hernia) and thence into the scrotum or labium. The sac of such a hernia may be (*a*) congenital or (*b*) acquired. Of the former there are several varieties.

Normally, the descent of the testis into the scrotum is followed by a closure of the process of peritoneum which the organ carries with it from the abdominal wall. This closure commences, above, at about the level of the external abdominal ring, and, below, immediately above the testis. The intervening or "funicular" portion of the tunica vaginalis is subsequently gradually obliterated. If this closure

does not occur at all, then the cavity of the tunica vaginalis testis communicates directly with the peritoneal cavity; and if a hernia descends, which is by no means necessarily the case, it will pass into a sac already formed, namely, the tunica vaginalis testis. Such a hernia is named "**congenital.**"

In other cases the tunica vaginalis testis becomes shut off from the general peritoneal cavity by adhesion

FIG. 114.

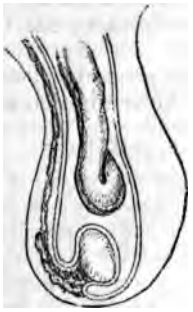


Diagram of a Congenital Inguinal Hernia. The loop of gut is within the tunica vaginalis testis.

FIG. 115.

Diagram of a Funicular Hernia. The loop of gut is in the unobliterated funicular portion of the tunica vaginalis, which has been separated from the testicular portion.

immediately above the testis, as already mentioned, but instead of the funicular portion of the peritoneal sac being obliterated, and closure occurring at the external ring, the funicular portion remains open and ready to receive any viscus that subsequently protrudes. To such a hernia the name of "**funicular**" is applied, for the sac is formed of the unobliterated "funicular" portion of the tunica vaginalis, the testis itself being separated from the hernial sac by a thin septum.

In yet other cases both the funicular and testicular portions of *the tunica* vaginalis remain unobliterated

and continuous with one another, but their cavity is separated from the general peritoneal cavity by the closure already mentioned, which normally occurs at the external abdominal ring. If a hernia now develop, the hernial sac is usually formed by a protrusion of a fresh portion of peritoneum from the neighbourhood of the internal abdominal ring, the sac being thus an acquired one. In such a case the hernial sac is liable to be protruded behind the unobliterated funicular portion of the tunica vaginalis, and, as it increases in size, tends to bulge into the cavity of the latter. A hernia with such a relation to the tunica vaginalis is named "**infantile.**"

Another variety of hernia is generally described which is said to be developed in connection with a

FIG. 116.

Diagram of an Infantile Hernia. The loop of gut is behind the unobliterated funicular portion of the tunica vaginalis, and is contained within a sac formed by a process of peritoneum pushed down from the neighbourhood of the internal abdominal ring.

FIG. 117.

Diagram of an Encysted Hernia. The gut is contained within a sac formed by an invagination of the upper part of the unobliterated funicular portion of the tunica vaginalis.

precisely similar abnormal condition of the tunica vaginalis to that last described. It is named "***encysted,***" and the sac is said to be formed by a

yielding of the adhesions at the point of closure of the funicular portion opposite the external ring. In this form of hernia the sac is invaginated into the unobliterated funicular portion, and is not placed completely behind the latter as in the infantile variety; much doubt, however, has recently been cast on the existence of true encysted herniæ by the investigations of Mr. Lockwood. Reference to the accompanying diagrams will render these various forms of herniæ more intelligible.

Interstitial hernia.—This form of hernia, called also "intra-parietal" and "hernie en bissac," is characterized by the presence of offshoots or pouches of the sac, which extend amongst the structures composing the abdominal wall. Thus, a sac may meet with some obstruction at the external abdominal ring, and may then extend either upwards, outwards, or inwards *behind* the aponeurosis of the external oblique. In other cases it passes through the external ring, but, meeting with difficulty in its further passage to the scrotum, extends between the skin and external oblique, and forms a swelling parallel to Poupart's ligament. Much more rarely the sac extends into the iliac fossa and passes between the iliac fascia and the peritoneum.

Acquired inguinal hernia.—In the case of an ordinary acquired inguinal hernia there is no abnormal condition of the tunica vaginalis to complicate matters, and the sac is formed in the manner already described in an earlier part of the present chapter. When an inguinal hernia becomes strangulated, the seat of constriction may be either the external or internal abdominal ring or the neck of the sac, but it should be remembered that when the sac is of congenital origin its neck is almost always the cause of the constriction.

In **femoral** herniæ the protrusion takes place at the crural ring, traverses the crural canal, and subsequently appears at the saphenous opening. The sac

is always an acquired one, and is not so capacious as is that of an inguinal hernia. The contents are usually part of the ileum with more or less omentum. If strangulation occurs, the seat of constriction is usually outside the sac, being at Gimbernat's or Hey's ligament or the deep crural arch. On account of the sharpness of these bands of ligament, the imprisoned gut ulcerates and sloughs more rapidly than is the case in inguinal herniæ, and it is well known to all surgeons that, on this account, the mortality after herniotomy for femoral hernia is greater than in the case of inguinal ruptures.

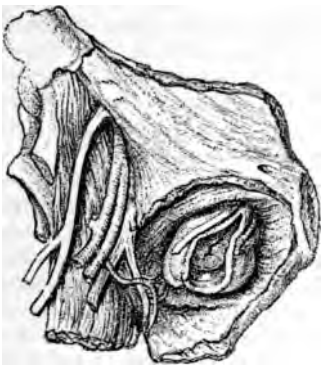
In **umbilical** hernia the abdominal viscera escape either through the umbilical ring itself or else through the linea alba in its immediate neighbourhood. This form of rupture is common in new-born children, and in them is readily curable by the application of slight pressure. When occurring in adult life, it is met with most commonly in very stout people with much intra-abdominal fat. In these the sac is usually of extreme tenuity, and is often gradually thinned away to such an extent that in places it becomes incomplete, the contents contracting adhesions to the surrounding parts and becoming irreducible. These contents almost always comprise omentum and jejunum, but in some cases the transverse colon is extruded. If strangulated, the seat of constriction is the aperture of exit in the linea alba, or adhesions formed by the omentum within the sac.

In **obturator** hernia the sac is always acquired, and is protruded through the upper part of the obturator foramen in company with the vessels and nerves of the same name. This variety of hernia is most common in thin, elderly women; the sac is always small, but sometimes causes pressure on, and pain in the course of, the obturator nerve. Strangulation is not common, and, when it occurs, the constriction is usually outside the sac and not very acute. (See Fig. 118.)

A **ventral** hernia is one in which the sac is formed

by a protrusion of peritoneum at a part of the abdominal wall in which normally no aperture exists. Such herniæ sometimes occur in the middle line between the recti muscles in women who have had prolonged and difficult labours, but are more often the sequel of wounds of the abdominal wall followed by formation of a weak and yielding scar. They are very rarely strangulated.

FIG. 118.



An Obturator Hernia. The sac protrudes through the upper part of the thyroid foramen, and the obturator vessels and nerve are stretched over its anterior surface.

Perineal and **sciatic** herniæ are extremely rare. In the former, the protrusion takes place between the anterior fibres of the levator ani; in the latter, through the sciatic notch, beneath the gluteus maximus.

Diaphragmatic hernia is either due to a congenital defect in the diaphragm or to injury. In the former case, the congenital aperture is almost invariably situated in the left half of the muscle; in the latter, it may be situated in any portion. In this form of hernia there is no true sac, the viscera escaping into the pleura, and, more rarely, into the pericardium. The *viscera which escape* are usually the stomach,

colon, and small intestine. Strangulation is rare, but is not unknown.

Littré's hernia is the term applied to either a strangulation of a Meckel's diverticulum or to the strangulation of a portion only of the whole circumference of a knuckle of intestine. To this latter condition the name of "partial enterocele" has more recently been given. Both these varieties of hernia are of interest, for although in neither of them is the whole calibre of the gut mechanically obstructed, nevertheless all the symptoms of strangulation are present. It is thus evident that the vomiting and constipation which accompany strangulation are not the result of simple mechanical obstruction, but are caused reflexly by the injury to, and irritation of, the constricted peritoneum.

In connection with the subject of hernia may be mentioned **protrusions of sub-peritoneal fat** through the linea alba. They usually occur about midway between the umbilicus and the ensiform cartilage, and form soft, partially reducible swellings, about the size of a walnut or a little larger, and increasing during any straining movements or in the act of coughing. Sometimes they can be reduced and the aperture of exit in the linea alba can be clearly defined, but in all cases where they have existed more than a few months they become irreducible. I have seen these swellings in both men and women above middle age, and have had opportunities of examining two of them post-mortem. They are liable to be mistaken for true herniæ, but the mistake is of little consequence, for they are well treated by the application of a truss.

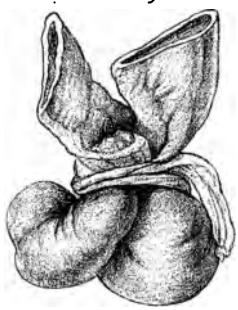
CHAPTER LIX.

INTESTINAL OBSTRUCTION.

THIS term is applied to all the various forms of mechanical obstruction of the intestines within the abdomen, as opposed to the external herniæ which protrude through the abdominal walls.

The following are the chief varieties of intestinal obstruction:—Internal herniæ; volvulus; intussusception; obstruction by foreign bodies and fæcal accumulation; stricture; tumours of the intestine; pressure on the bowel from without by tumours, &c.; chronic peritonitis.

FIG. 119.



An Internal Hernia. A loop of small intestine is strangulated by a band of adhesions.

The term **internal hernia** is applied to cases in which intestine has become constricted by bands of adhesions or of omentum, or by slipping through apertures in the omentum or mesentery or into such normal openings as the foramen of Winslow and the inter-sigmoid fossa. Bands of adhesion are formed as the result of peritonitis, and are most common in the right iliac fossa, though they may occur in any part of the abdomen. Portions of omentum may also become adherent from peritonitis or by inclusion in

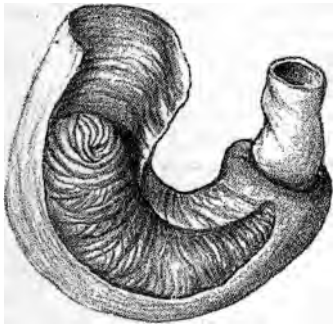
the sac of an irreducible hernia. In other cases bands are formed in connection with a persistent Meckel's diverticulum. This latter, when present, is a pouch or offshoot of the small intestine, formed by an undue persistence and development of the vitelline duct. It is situated about 2 feet above the ileo-cæcal valve, and varies in length from an inch to a foot. In some cases it is adherent to the umbilicus from birth; in others, it contracts adhesions to some other part of the abdominal parietes; whilst very frequently it remains free and movable in the abdominal cavity. When adherent, coils of intestine may be caught around or compressed by it; whilst in some few instances, when free, it has been known to knot itself round the mesenteric attachment of a knuckle of bowel. Strangulation of intestine from slipping through apertures in the omentum, into the foramen of Winslow, &c., is of very rare occurrence, and does not require further comment.

Volvulus, or twisting of the intestine, is most often seen in the sigmoid flexure, but is nowhere common. In cases where the sigmoid flexure is unusually voluminous, large coils of the gut sometimes protrude almost at right angles from the course of the descending colon. The size of these coils is in most cases acquired, and appears to be the result of chronic constipation; in such cases the meso-colon is also longer than natural. If this part of the bowel is distended by fæces, it may happen that these coils become doubled over by the weight of their contents, and so twisted upon their mesenteric axis, and kinked, that both the passage of fæces and the free circulation of blood in the mesenteric vessels are interfered with, and strangulation results. In such cases gangrene and peritonitis rapidly ensue. Much more rarely a similar form of volvulus is found in the ascending colon, whilst the same portion of bowel has also been seen twisted around its own longitudinal axis. The cæcum also, especially when imperfectly developed, *ha* own to be the seat of a twist. Volvulus

of the small intestine is met with only in connection with previous peritonitis and adhesion of loops of intestine; it is extremely rare.

Intussusception.—In intussusception one portion of the intestinal tube is invaginated into the lumen of that portion of intestine with which it is immediately continuous below. A complete intussusception consists of three cylinders or rings of bowel. The innermost of these is named the entering layer; the middle, the returning layer; and the external, the sheath. Intussusception is most common in children, and

FIG. 120.



An Intussusception. The sheath has been laid open so as to show the intussuscepted portion.

usually originates at the junction of the ileum with the cæcum. In this situation the ileum, with the ileo-cæcal valve, is pushed into the more capacious cæcum. If the intussusception now continues to increase, it does so at the expense of the colon, more and more of which is rolled in by the constant and excessive vermicular contraction of the intestines. It thus happens that the apex, or presenting part, of the invaginated bowel, or the "intussusceptum," throughout the development of the affection always consists of the same *portion of* gut which originally became

intussuscepted, namely, the ileum and the ileo-cæcal valve, and thus in some cases the latter may present at the orifice of the anus. This form of intussusception is named **ileo-cæcal,** but another and much more rare form, named **ileo-colic,** is met with, in which the ileum becomes inverted *through* the ileo-cæcal valve, and the intussusceptum increases by protrusion of additional portions of ileum. Intussusceptions are also found in the small intestine and in the descending colon and sigmoid flexure, but seldom attain a large size. All true intussusceptions may easily be distinguished from similar invaginations which are formed sometimes during the irregular movements of the intestine which occur not uncommonly just before death. These latter intussusceptions are always small, frequently multiple, easily reduced, and the gut is not congested.

If an intussusception remain unreduced, congestion and subsequent sloughing of the imprisoned bowel is apt to ensue. In some cases an intussusception persists for a considerable time without serious mischief resulting, but such instances are comparatively rare, and much more commonly the circulation in the intussuscepted gut is quickly interfered with by the traction on its mesentery. The intussusceptum swells from venous engorgement, and very soon blood escapes from the distended vessels into the interior of the intestine, as well as into the wall of the gut itself. The swelling causes, in its turn, a greater constriction of the intussusceptum where it enters the sheath, the arterial circulation is arrested, and gangrene results. In its early stages an intussusception may be reduced, but later on this becomes impossible. The irreducibility is in great part the result of the swelling already mentioned, but, in addition, adhesions soon form between the sheath and the returning layer, and fix the latter in its abnormal position. In almost all cases there is an extension of inflammation from the inflamed or sloughing intestine to the neighbouring

peritoneum, and peritonitis results; whilst sometimes the sheath itself becomes ulcerated, or even gangrenous. Spontaneous cure is less rare than is generally supposed; the gangrenous intussusceptum is cast off as a slough, and the patient recovers with an intestine which is shortened in proportion to the length of that piece which has sloughed, the continuity of the canal being established by the adhesions which form between the sheath and the returning layer.

It is not easy to assign a definite cause to each individual case of intussusception, but it is probable that all owe their origin to irregular and excessive contractions of the bowel, such as occur in colic, or result from the presence of any hard or foreign body in the intestine. In some cases the trouble may be traced to the presence of a polypus, which, being gripped by the bowel below its seat of attachment, is drawn in, together with the gut from which it grows, during peristalsis.

Obstruction by foreign bodies and fæcal accumulations.—It is not often that intestinal obstruction results from the presence of foreign bodies, unless in this category hardened fæces be included. The various foreign bodies which are so frequently swallowed are seldom of sufficient size to block the intestine, whilst yet small enough to safely pass the œsophagus and stomach. They may, it is true, lodge in the cæcum or some other part of the alimentary tract, and cause grave trouble by setting up ulceration, with the subsequent formation of fæcal abscesses or fistulæ, or may induce peritonitis; yet, withal, they seldom entirely obstruct the calibre of the intestine. A more frequent cause of obstruction is a gall-stone, and it is probable that, when it is of sufficient size to become impacted, it has gained the cavity of the bowel rather by ulcerating from the gall-bladder into the duodenum than by passing along the gall-duct, for it is difficult to conceive that a stone which *would traverse* the latter could block the gut.

Intestinal calculi, or enterolithes, are of rare occurrence, they are usually composed of phosphatic deposits formed around some foreign body, or of masses of hair or fibre; these latter are generally met with in hysterical subjects or lunatics. In other cases the calculi are composed of vegetable matter, or of masses of insoluble salts, such as magnesia, which have been taken medicinally. Any of these forms of enterolithes may attain great size, and completely obstruct the bowel.

Fæcal accumulation is the result of long-continued and neglected constipation, and is seldom seen in early life. The accumulation is necessarily gradual, and is most common in the cæcum, sigmoid flexure, and rectum. In such cases the intestine, which is already feeble and slow to contract, becomes still more paralysed by the distension and pressure of the contained mass, and, should the condition remain unrelieved, complete cessation of all peristalsis results. In addition to the mechanical blocking of the bowel, the fæcal mass, which becomes harder and dryer the longer it is retained, causes inflammation and ulceration of the intestine, and, subsequently, localized chronic peritonitis, the gut above the obstruction becoming also immensely distended. In other cases fæcal masses not large enough to occlude the intestine remain in the cæcum and keep up persistent irritation, perhaps for months.

Stricture of the intestine.—Except in the rectum, stricture is rare, and the forms of narrowing in this part of the bowel will be dealt with more fully in the chapter on Diseases of the Rectum. The simple strictures of the intestines are, like those of other mucous canals, caused by the contraction of scar tissue at the seat of previous ulceration, those ulcers which are most often followed by such contraction being the dysenteric, the catarrhal, the tubercular, and the syphilitic. The strictures caused by the two first of these are most common in the large

intestine; those by the two latter, in the lower part of the ileum and the cæcum.

Tumours of the intestine (not including the rectum).—Both innocent and malignant tumours are met with in the intestine, the latter being unfortunately the more common.

Of the innocent growths, the simple glandular polypus is of most frequent occurrence. It is seen in children, and is sometimes multiple. Its common site is the lower part of the ileum and the colon. It is seldom large enough to obstruct the bowel, but, as already mentioned, may cause intussusception. Fibrous, nævoid, and fatty growths are very rare.

Malignant tumours are much more common in the large than in the small intestine. They are almost invariably carcinomatous, and frequently belong to that variety of malignant growth to which the name of adenoid cancer has been given. These growths become more common the nearer we approach to the anus, but are more frequent in the cæcum than in the ascending colon. They cause much induration and narrowing of the intestine, with the formation of a so-called "cancerous stricture." The growths themselves ulcerate, and may furnish a discharge of blood-stained and foul fluid from the anus. Above the stricture the gut becomes dilated, inflamed, and often ulcerated, so that perforation of the bowel and acute purulent peritonitis frequently induce a fatal termination. On post-mortem examination, it is by no means rare to find no secondary growths in any of the viscera, and in a considerable number of cases there is no glandular affection. In some cases the growth is tuberous, and protrudes into the cavity of the bowel; in others, it forms a hard ring in the wall of the gut itself.

Pressure on the bowel from without by tumours, &c.—This is not a common cause of obstruction, for the bowel, being in most parts movable, is not readily compressed. Cancerous growths, from *their tendency to fix* and adhere to the tissues, more

often cause obstruction than innocent tumours, and as examples may be quoted cancer of the pancreas, spleen, kidney, and liver. In other cases, uterine, ovarian, or prostatic tumours compress the bowel, and in yet another class the obstruction is caused by the pressure of pus. Thus, I have seen a case in which an abscess which formed in Douglas's pouch as the sequel to rectal stricture and ulceration caused such pressure on the bowel as to induce death by obstruction, and other similar cases have been recorded. Occasionally, the glandular tumours which result from "tabes mesenterica" attain a sufficient size to compress the bowel, to which, in addition, they may contract adhesions.

Chronic peritonitis.—In tubercular disease of the peritoneum it is by no means uncommon for the coils of intestine to become matted to one another and to the enlarged glands which are often present. In consequence of this matting, a chronic form of obstruction may supervene. The condition is most common in young people. In another class of cases the peritoneal inflammation is dependent upon disseminated new growth. This is most frequently seen in connection with malignant ovarian disease, but in some cases the growth is primary in the serous membrane.

CHAPTER LX.

DISEASES OF THE RECTUM.

IMPERFORATE ANUS.

IMPERFORATE anus results from imperfect union between the rectum above and the posterior part of the cloaca common to the uro-genital aperture and the hind gut below.

The deformity exists in varying degrees. In some cases there is an anal depression, at the bottom of which a membrane forms a septum separating the anus from the rectum, or else the anus itself is occluded by a similar membrane, which extends backwards from the scrotum to the coccyx. In other cases, again, the anus and rectum are continuous, but the gut is much narrowed at the point of their junction, and occasionally the anal orifice is obstructed by a longitudinal fold of skin extending from the coccyx to the scrotum, and bisecting the anal aperture.

In more severe examples the anal aperture is separated from the rectum by fibrous tissue an inch or more in depth, whilst in some instances the rectum itself is completely undeveloped. Not infrequently the rectum opens into the genito-urinary tract—in the female into the posterior wall of the vagina, and in the male into the prostatic urethra; more rarely, the opening is into the bladder itself. Those cases in which there is no passage for fæces terminate fatally

unless subjected to surgical treatment, the infant dying from vomiting and exhaustion, or from rupture of the cæcum or colon caused by over-distension.

HÆMORRHOIDS.

Hæmorrhoids, or piles, constitute one of the most common of the diseases to which the rectum is liable. A hæmorrhoid is essentially a dilated or varicose vein, or more often a collection of such veins. According to their situation relative to the anal orifice, piles are called external or internal, but, although it is not uncommon to find internal piles existing alone, external piles are almost always associated with the internal variety.

External piles are covered by skin, and are generally multiple. When not inflamed, they give rise to but little trouble, and present themselves as swollen tabs of skin around the anal orifice. When inflamed, they form purple, shiny, tense, rounded masses, causing much pain and rectal tenesmus. If removed, they are found to consist of a looped varicose vein surrounded by fibrous tissue, the quantity and denseness of which depend upon the frequency with which the pile has been the seat of inflammation. Very commonly, the blood in the varicose vein clots when the latter becomes inflamed, and occasionally suppuration or sloughing terminates the existence of a hæmorrhoid.

Internal piles vary in structure, for, although all are composed of dilated vessels, the arrangement and character of the latter are not always identical. They may conveniently be divided into (*a*) capillary, (*b*) venous, (*c*) arterial.

Capillary piles are small, sessile swellings, with a papillated, mulberry-like surface which readily bleeds. This hæmorrhage, which is common in all cases of internal piles, is readily accounted for when we consider that the latter are covered by thin mucous membrane only, and not by skin, as are the external

ones, and that, in addition, they are exposed to the pressure and irritation of the hardened fæces of the rectum. Children are but seldom the subjects of piles, but when such is the case it is the capillary pile which is almost always found.

Venous piles are the most common of the internal hæmorrhoids. They are usually multiple, and extend from just inside the anal margin to a distance of one or two inches up the rectum. They form irregular pedunculated swellings, purple in colour, soft in consistence, and not so prone to bleed profusely as the capillary

FIG. 121.

The Inner Surface of a Rectum with some Large Internal Piles.

variety. On section after removal, they are seen to be composed almost entirely of irregular varicose veins, surrounded by but little fibrous tissue, and a few small arterioles.

Arterial piles are comparatively rare. They are generally large, distinctly pedunculated, smooth and slippery on the surface, and readily bleed *per saltum* if scratched. They contain arteries of considerable size, as well as varicose veins.

The **causes** of hæmorrhoids are numerous, but, in general terms, it may be said that they are induced by anything which impedes the return of blood from the rectum. It should be remembered that most of the rectal veins open into those of the portal system, and that, as the latter have no valves, the blood-pressure at the most dependent parts of the rectal vessels is necessarily considerable. In addition, the veins of the rectum run in a submucous tissue, which is more than usually lax and yielding—a condition which, although necessary on account of the constantly varying distension of the rectum, nevertheless gives but little support to the veins. Chronic constipation, which is one of the most fertile causes of piles, induces them in more ways than one. First, the fæcal masses compress the veins directly, and, secondly, the thickening of the muscular coat of the rectum, which often results from its distension, causes an increased difficulty in the flow of blood from the veins of the submucous tissue.

But the pressure on the rectal veins is often caused by diseased conditions of the rectum itself, and it should always be remembered that almost any disease of the rectum may be complicated by piles; this is a fact that has more than a pathological importance, for, if it is not recognized, the more serious mischief may be overlooked, and an operation be undertaken for the cure of piles when the latter are perhaps but a complication of a rectal stricture or new growth. In some cases pressure on the rectum may be caused by a pregnant uterus or a uterine fibroid, and in old men by an enlarged prostate. The impediment to the portal circulation caused by a congested liver, often the result of excessive indulgence in food and drink, and still more that caused by cirrhosis of the liver, tends to cause piles, whilst, in addition, the conditions which produce a more general congestion of the venous system, such as diseases of the heart and *lungs*, also exercise some influence.

Lastly, sedentary occupations and a feeble state of health, with loss or impairment of healthy muscular tone, such as is sometimes induced by residence in hot climates, must be mentioned as causes of hæmorrhoids, and it is probable that heredity is not without some influence, for in not a few cases hæmorrhoids occur in several members of the same family.

ISCHIO-RECTAL AND ANAL ABSCESS AND FISTULA IN ANO.

The abscesses which are common in the neighbourhood of the rectum and anus fall naturally into two divisions—those which are superficial and those which are deep. To the former the name of **anal** abscess is often applied, for they develop in the folds of skin which surround the anus. They never attain any great size, and readily burst externally; if they burst internally as well, the most usual place for the formation of the internal opening is the line of separation between the external and internal sphincters, *i.e.*, just within the anus itself.

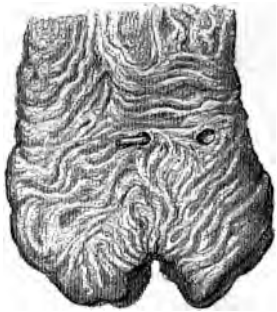
The deep or **ischio-rectal** abscesses are formed in the fossa of that name. They are situated beneath the deep fascia, and show but little tendency to come to the cutaneous surface, meeting with less resistance in their extension toward the bowel, into which they often burst above the upper margin of the internal sphincter, *i.e.*, about an inch and a quarter to an inch and a half up the rectum. Their formation is accompanied by much brawny swelling, with induration and pain.

Both anal and ischio-rectal abscesses may result from injury or exposure to wet and cold. Usually the injury is applied from without, but the presence of hard and sharp foreign substances in the rectum provides another source of traumatism, for by their passage through the mucous membrane they may allow of the escape of minute quantities of fæcal matter into the cellular tissue, and thus promote sup-

puration. The anal abscesses appear to owe their commencement in many cases to the irritation caused by want of cleanliness in this region.

A fistula in ano is the result of an unhealed abscess, and just as there are two kinds of abscesses, so are there two kinds of fistulæ. It must not be supposed that all abscesses in the neighbourhood of the rectum refuse to heal, for such is not the case, but, as a very large number of them lead to the formation of fistulæ, it is evident that some common cause or causes must be present in all cases. One of the most constant of these is the perpetual movement of the parts, for not

FIG. 122.



The Inner Surface of a Rectum with Two Small Tubercular Ulcers, into one of which a portion of glass rod has been passed.

only are the walls of the abscess drawn upon during defæcation or the passage of flatus, but the perineum is kept in motion by any violent respiratory act, and especially by coughing. Another fertile source of fistula is the passage of fæcal matter, and the irritation which is thereby set up whenever the abscess-cavity communicates with the bowel. The association of fistula with phthisis finds an explanation in the presence of tubercular ulceration of the rectum in this disease. The ulcer, which is generally ragged, with undermined edges, permits the escape of fæcal

matter, as already mentioned, and causes suppuration around the gut. Lastly, as in the case of piles, it must constantly be kept in mind that a fistula may be but a complication of some other rectal disease, such as simple or cancerous stricture, syphilitic ulceration, fissure, &c.

Three chief **varieties** of fistula are described—the complete, the blind external, and the blind internal. A **complete** fistula is one which opens both externally through the skin and internally into the bowel; strictly speaking, this is the only form of true fistula, the others being sinuses. A **blind external** fistula is one which opens externally alone, but is "blind" towards the rectum, and, conversely, a **blind internal** fistula has an opening into the rectum alone, and none through the skin. The external opening is usually close to the anus, but in some cases is situated at a distance of several inches, or, in rare instances, as far away as the great trochanter. In healthy subjects this opening is small, and from it protrudes a small mass of healthy florid granulations. In phthisical patients the aperture is often large and ragged, the skin undermined and purple, and the base devoid of healthy granulations, and secreting a little watery pus.

The position of the internal opening depends chiefly on the kind of abscess which has preceded the fistula. If an anal one, then the aperture is just inside the anus, between the external and internal sphincters; whilst if an ischio-rectal one, the opening is placed above the internal sphincter, and is sometimes as much as three or even four inches from the anus. The character of this orifice differs, as does that of the external one, according to the constitutional condition of the patient. The fistulous track itself is lined at first by the granulation tissue of the shrunken abscess-cavity, but in cases of long standing the wall becomes thickened by fibrous tissue, and the canal is lined by a dense cicatricial membrane, showing no tendency *whatever to heal.*

A fistula chiefly causes trouble by the discharge of matter and the incontinence of flatus and fæces, but, if it be neglected, further mischief will ensue. On account of the occasional blocking of the track, pus is liable to be retained at times, fresh abscesses form, and either burst again through the old opening or else point in fresh places. In this way other fistulous tracts are produced, which in many cases form branching channels leading from the original sinus. As this

FIG. 123.

A Rectum with Numerous Fistulæ and much Fibrous Thickening.

trouble is continuous so long as it is allowed to remain untreated, additional openings form in the bowel, the mucous membrane is destroyed by ulceration, and the submucous and muscular coats are infiltrated by fibrous tissue and other inflammatory products. In this manner the lower part of the bowel is converted into a tough fibrous tube, incapable alike of properly retaining fæces and of transmitting them, for the sphincters cease to act, not only because they are *partly* destroyed, but also because the mucous surface

no longer maintains its normal sensibility, and thus the presence of fæcal matter is not recognized by the patient, and does not excite the natural reflex contraction of the muscles. On account of the contraction of the newly formed fibrous tissue, much narrowing may ensue, and thus lead to the development of a stricture. Some few cases terminate fatally from exhaustion, caused by profuse suppuration; others, from acute peritonitis consequent on the perforation of an ulcer through some part of the rectum covered by peritoneum.

ANAL FISSURE.

In fissure of the anus there is, as the name implies, a crack or fissure at the anal orifice. In very many cases no other cause is apparent beyond chronic constipation, and it is probable that the disease generally results from over-distension by hardened masses of fæces. In some instances the fissure is slight and readily heals even without treatment, but usually it extends, and shows little tendency to spontaneous cure. The common situation of a fissure is the posterior margin of the anus; it usually reaches about half an inch or more up the bowel, and an examination may show that it is complicated by the presence of either piles or a polypus. It is of some importance to recognize such a complication, for, if the growth be not removed, the treatment of the fissure is liable to prove abortive. Fissures cause much pain, which is especially severe after defæcation, and it is supposed that both this symptom and their slowness to heal are alike accounted for by the exposure of nervous twigs in the floor of the fissure.

ULCERS OF THE RECTUM.

Simple ulceration of the rectum is usually of traumatic origin, and is the result of the presence of hardened masses of fæces or of foreign bodies in the rectum. The *ulcer is* usually single, and may be

situated at any part of the circumference of the bowel. It is seldom larger than a shilling, and is of no regular shape; its base and edges are neither indurated nor unduly prominent. As already mentioned, ulceration of the rectum may lead to the formation of a fistula, and the fistula, in its turn, may be followed by an ulceration which extends up the rectum, and sometimes involves the mucous membrane in the greater part of its length.

Syphilitic ulceration is more common in women than in men, and is usually a tertiary affection. It may, however, be said at once that cases are attributed to syphilis in which there is no evidence of this disease, and it is probable that many instances of so-called syphilitic disease are really examples of simple ulceration extending up the gut, as already described in the chapter on Fistula.

FIG. 124.

The Inner Surface of a Rectum with Syphilitic Ulceration, which has in part destroyed the mucous membrane.

In typical syphilitic disease the mucous membrane of the rectum is thickly studded with small oval or rounded ulcers, the size of a pea or a lentil. These have at first but little induration of their bases, and the edges are sharply cut, and not overhanging like those of a tubercular ulcer. By their increase in size, these ulcers coalesce, and thus the mucous membrane is destroyed over an area of irregular shape. The infiltration of the rest of the rectal wall by the products of inflammation results after a time in the production of fibrous tissue, and is followed by induration and contraction of the calibre of the gut. The ulceration tends to spread up the bowel, and in this way there

is first a destruction of the mucous lining and then a formation of fibrous tissue, which may in time implicate the rectum in its whole length. The discharge from the ulcerated surface is often very profuse, and in some cases the ulcers penetrate deeply into the surrounding parts. In consequence of this penetration, fistulæ are liable to form, and in some cases extend into neighbouring organs, such as the vagina or the bladder. If an ulcer penetrates the rectal wall where the latter is covered by peritoneum, acute suppurative peritonitis quickly ends the patient's life. In other cases death results from exhaustion. In connection with this subject, it may be mentioned that in secondary syphilis the anus is very frequently the seat of condylomata or mucous tubercles, such as have been more fully described in the chapter on Syphilis.

Tubercular ulceration of the intestine, and the part it plays in the production of fistulæ, have already been described, and it now only remains to mention briefly the other and rarer causes of ulceration. These are chiefly **dysentery** and **catarrh**, for the ulceration which is the almost constant accompaniment of new growths is better dealt with in connection with tumours of the rectum. Dysenteric ulceration is often very chronic, and may persist for years. The scars left by it are frequently pigmented. In rare cases it causes penetration of the rectal walls, with the formation of fistulæ. It is peculiarly liable to be followed by abscess of the liver.

STRICTURE OF THE RECTUM.

Rectal stricture results either from inflammation and ulceration or from the presence of new growths. Any of the varieties of ulceration described above may result in the formation of a simple stricture, which, in addition, may ensue upon pelvic cellulitis or other forms of *inflammation* connected with the female

genital organs. In some cases stricture close to the anal orifice is dependent upon imperfect development of the communication between the bowel and the skin surface. Occasionally, stricture results from the too free removal of skin in operations upon hæmorrhoids.

Stricture occurs in all parts of the rectum, and may be either annular or tubular. In the former, there is a narrow ring-like contraction of the gut; in the latter, the rectal walls are infiltrated in a considerable part of their length. In many cases in which there has been extensive ulceration, and the stricture is of long standing, the lowest portion of the gut is found, when examined by the finger, to be extremely rough and irregular, the walls being exceedingly hard and resistant, and the bowel fixed to the surrounding parts. The rectum above the stricture becomes greatly hypertrophied and dilated on account of the obstruction to the passage of fæces, and, on account of the retention of the latter, is liable to become inflamed and ulcerated. The ulceration, in its turn, is followed by contraction of the scar tissue, and thus the stricture extends.

The ulcerated and dilated condition of the gut above the obstruction affords a ready explanation of some of the most typical symptoms of stricture. It is common in these cases to have a history of alternating attacks of constipation and diarrhœa. The constipation is the result of the accumulation of fæces above the stricture, and it is the presence of the fæcal masses which causes irritation and catarrh of the bowel, resulting in discharge of the accumulated fæces mixed with, and liquefied by, the secretion of the intestine. The ulcerated surface also supplies a discharge of pus and mucus, which collects above the sphincters, and causes frequent desire to defæcate, the patient passing a mixture of pus and blood. When the stricture is near the anus, the motions are moulded by it rather than by the anal orifice, and become narrow and pipe-like; but if the obstruction be in the upper part of the

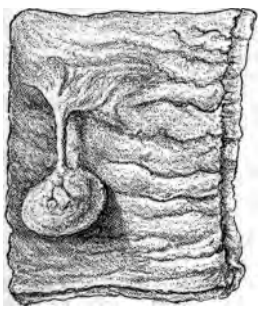
rectum, the fæces collect again below the stricture, are welded by the muscular rectal walls, and finally shaped by the anus, so that any narrowing which has been produced in the passage through the stricture is lost in the rectum below it.

Stricture of the rectum may end fatally in more ways than one. In some cases the discharge from the ulcerated surface causes death by exhaustion or amyloid disease; in others, additional trouble results from the implication of the bladder and the formation of a fistulous communication; sometimes peritonitis is caused by the penetration of an ulcer high up the bowel; and, lastly, the opposition to the passage of fæces may culminate in complete intestinal obstruction.

TUMOURS OF THE RECTUM AND ANUS.

Tumours of the rectum, like those of other parts, are either innocent or malignant; the former will be first described.

FIG. 125.



Portion of a Rectum with a Pedunculated Glandular Polypus.

Papillomata are sometimes, though not frequently, met with around the anal orifice. They present the *same appearances as* similar growths elsewhere, being

roughened on the surface, not indurated nor infiltrating the surrounding tissues, and often discharging a watery, blood-stained fluid. They are usually small, but occasionally attain considerable proportions. They occur chiefly in adults.

Polypi are found at all ages, but are relatively common in children. They are either (*a*) glandular or (*b*) fibrous. The **glandular** or adenomatous polypi are usually about the size of a small hazel-nut, are attached by a stalk or pedicle which is often an inch or two in length, have a papillated surface, and are prone to bleed. In rare instances they are multiple, and may be numbered by hundreds, extending up the rectum as far as the finger can reach, and bleeding profusely. On microscopical examination, these glandular growths are found to consist of numerous Lieberkuhn's follicles closely set in a matrix of loose fibrous tissue.

FIG. 126.

A Rectum with Multiple Glandular Polypi.

The **fibrous** polypi are not so common as the adenomatous ones. Their surface is smoother, their pedicles shorter, and their tendency to bleed not so marked as in the case of the glandular polypi. Sometimes they attain a very considerable size, and there is a specimen in the museum of St. Bartholomew's Hospital which was removed by my friend Mr. Everley Taylor *from* a girl of about twenty, and weighed no less *th* nd. Such cases are, however, extremely

rare. On microscopical examination, these polypi are seen to be composed of loose connective tissue; sometimes they are very soft, and contain much serous fluid in the connective-tissue spaces.

Dermoid tumours of congenital origin, and polypoid in shape, have been occasionally met with in the rectum; they are sometimes covered by long silky hairs.

Nævi are very rare, but are liable to be dangerous to the life of the patient by reason of the copious hæmorrhage which they occasionally cause. Like similar growths in other parts, they are met with in children.

Malignant tumours of the rectum are practically always carcinomata, for the sarcomata are so rare that they do not require separate mention. But, although all the malignant growths are of epithelial origin, they are not all alike either in their physical properties or microscopical structure, and may conveniently be divided into two classes—(*a*) the adenoid or glandular cancers and (*b*) the scirrhous cancers.

The **adenoid carcinomata** have been shown by Mr. Cripps to form the greater number of the malignant tumours of the rectum. They may grow in any part of its length, but are of more frequent occurrence in the lower than in the upper part of this portion of the bowel. They grow from the mucous membrane, and show a great tendency to extend into the lumen of the gut. At first they are covered by the mucous membrane, and form soft, partially pedunculated, smooth masses, movable on the deeper part of the rectal walls. As they increase in size, their surface becomes ulcerated and discharges a mixture of blood and mucus, their deeper portions grow into, and gradually implicate, the whole rectal wall, and, chiefly as the result of irritation, they become more firm and indurated. Their growth is not rapid, and may extend over periods of even four or five years or more. Sometimes *they implicate* neighbouring organs, and

cause fistulous openings into the bladder or vagina, or on to the neighbouring cutaneous surface. In some instances they neither infect the lymphatic glands nor cause secondary growths, but at other times the reverse is the case, and the liver more than the other viscera is liable to metastatic deposits.

On microscopical examination, adenoid cancers are found to be composed of a loose fibrillar stroma, in which are embedded numerous tubular glands lined with columnar epithelium, as well as masses of epithelial cells lying loose in alveoli, and not forming any definite

FIG. 127.

The Inner Surface of a Rectum with an ulcerated mass of Adenoid Carcinoma.

glandular structure. In these tumours, indeed, there may often be seen all gradations of structure between a definite adenoma and a typical carcinoma, and, as a result, there are many irregularly formed and imperfectly developed gland-tubules. It is not always easy to say at first sight whether a given growth is a simple adenoma or an adenoid cancer, but the point may be settled by noticing whether or not the *growth* implicates the submucous and muscular coats. *If it does* so, then the tumour must be looked upon as

malignant; whereas if it is only a surface-growth, not infiltrating the rectal wall, it must be considered a simple glandular polyp.

Scirrhous cancers are more common in the lower than in the upper part of the rectum. Unlike the adenoid cancers, they do not tend to the formation of polypoid-like masses protruding into the cavity of the

FIG. 128.

Section of an Adenoid Carcinoma of the Rectum showing the irregular cavities lined by columnar epithelium. (Zeiss, A.)

bowel, but rather simply infiltrate its walls. Both the glandular cancers and the scirrhous growths cause a narrowing of the calibre of the gut, and produce the so-called malignant stricture of the rectum, but the scirrhous growth is much more dense and fibrous, and by its contraction renders the rectal walls infinitely *more rigid* and undilatable than does the

adenoid carcinoma. The mucous membrane covering the tumour ulcerates early, and exposes a readily bleeding surface, which discharges a foul-smelling and watery secretion. The growth may extend into the neighbouring viscera and tissues, and sometimes attains so great a size as to fill the lower aperture of the pelvis and compress all the pelvic viscera. The bowel above the growth becomes dilated and ulcerated, as in the case of other strictures, and in some instances the disease is complicated by the formation of fistulæ or of piles. Glandular enlargement and metastatic growths are of common occurrence, and death ensues either from visceral disease, or else, more commonly, from exhaustion induced by pain and profuse discharge or from intestinal obstruction. On microscopical examination, these tumours show the dense fibrous stroma arranged so as to form alveoli of irregular shape and size, such as are common to all scirrhous growths. The epithelial cells contained in the alveoli are in some cases spherical but more often columnar in shape.

PROLAPSUS ANI ET RECTI.

The former of these terms is applied to an abnormal protrusion or eversion of the mucous membrane of the rectum through the anal orifice; the latter, to an eversion of the whole thickness of the rectal wall. The mucous membrane of the rectum is normally so loose that it protrudes slightly during defæcation, and anything which causes excessive straining will result in excessive protrusion or prolapse. The commonest cause of prolapse of the anus or rectum is intestinal irritation caused by the ingestion of unsuitable food, and we thus find the disease most often in unhealthy, ill-fed, flabby, and rickety children. Any disease of the rectum may be complicated by prolapse, but those which most often induce the trouble are rectal polypus, piles, and thread-worms. Prolapse is also liable to *result* from any disease of the urinary organs which

induces straining, and is common in children suffering from phimosis or calculus.

The extent of the prolapse varies greatly; in some cases only a small fold of mucous membrane protrudes, whilst in others several inches of the lower part of the rectum projects as a tube from the anus; the prolapse tends to increase so long as its cause remains. At first the mucous membrane is everted only during straining, but as time goes on the sphincters become lax and atonic, the attachment of the mucous membrane to the submucous tissue less and less firm, and, finally, the bowel is more often prolapsed than not. The result of the constant exposure is an inflammation of the mucous lining, accompanied by a catarrhal discharge, and in cases of long standing this may be succeeded by ulceration or even sloughing of the prolapsed parts, the latter being usually the result of a strangulation of the protrusion by the anal orifice.

PRURITUS ANI.

This is a term applied to a sensation of itching and irritation of the anus and surrounding skin. It sometimes complicates piles, or may result from the presence of rectal worms, but is most often caused by over-feeding and its accompanying constipation and congested liver; it is also common in gouty subjects. As a result of the irritation and consequent scratching, the skin may become eczematous.

CHAPTER LXI.

PERITONITIS.

INFLAMMATION of the peritoneum may be either acute or chronic, diffuse or localized. The acute inflammations are usually also diffuse, but the chronic are not necessarily localized, although this is frequently the case.

Acute diffuse peritonitis is a septic, spreading inflammation of the peritoneum. It may result from such causes as penetrating wounds of the abdominal wall; extension of inflammation from neighbouring parts—*e.g.*, from the cellular tissue in cases of urinary extravasation; rupture of the stomach or bowel or their perforation by ulcers, tumours, or foreign bodies, and the escape of the intestinal contents—so-called "perforative peritonitis;" rupture of abscesses into the peritoneum, especially of perityphlitic abscesses; gangrene of the gut following strangulation or any of the varieties of intestinal obstruction; and septic conditions of the system, such as septicæmia and pyæmia.

The commencement of peritonitis is marked by a great distension of the vessels, and a consequent reddening of the inflamed part. This is usually very noticeable, and at once attracts attention when the abdomen is opened at a post-mortem inspection. As the inflammation progresses the redness becomes less noticeable, the surface appears dull, and on closer examination this alteration in colour is found to be the result of exudation, which covers the inflamed

parts with a thin layer of fibrin, and causes the surface of the intestine to assume a finely granular or ground-glass appearance. Very soon, as the exudation increases, the serous surface becomes flocculent, and shreds of fibrin in the form of a fine network may be seen crossing each other in an irregular fashion. The fibrin also causes adhesion of the folds of intestine, so that the latter are found to be stuck together and partially fixed to the parietal peritoneum. The intestines themselves are greatly distended, and contain large quantities of gas—a condition which results from paralysis of their muscular coats.

In the later stages of septic peritonitis, the serous cavity is more or less filled by fluid, which at first is serous and blood-stained, but soon assumes a flocculent appearance, with shreds of fibrin floating in it, and finally becomes purulent. The fluid collects in the most dependent parts, and especially in the pelvis, but it is also prone to become localized by adhesions formed between the intestinal folds, and may thus form collections shut off in parts from the general peritoneal cavity. The intestinal walls are also swollen by exuded fluid, and softened so that they are easily lacerated; in some cases the distended capillaries give way, and cause small sub-serous petechiæ or ecchymoses.

Microscopical examination shows that in the early stages of the affection there is an exudation of serum and leucocytes, and a separation of the endothelial cells which line the serous membrane. As the inflammation progresses both red blood-cells and the fibrin-forming elements of the blood exude, and the coagulated fibrin is deposited on the inflamed surface or floats in flakes in the exudation. More and more leucocytes make their appearance, and soon the fluid is so laden with them as to become sero-purulent or purulent. Sometimes free gas, the result of decomposition, is found in the abdominal cavity. In acute diffuse peritonitis *the conditions* described are found in all

parts of the serous membrane, but where, as is usually the case, the inflammation has extended from some definite place, there all the signs will be found more accentuated and advanced than elsewhere.

Peritonitis, in the absence of treatment, is almost invariably fatal. It is accompanied by severe collapse, with persistent sickness and constipation, and the general symptoms of septic poisoning. In otherwise healthy adults there is usually severe pain, and, at first, pyrexia; but in old and feeble patients there is often but little pain, and the temperature is frequently sub-normal.

Sub-acute and chronic, localized peritonitis commonly results from an extension of some inflammatory process in or around one of the viscera. Thus, it is frequently caused by inflammation of the cellular tissue around the cæcum, of the uterus or ovaries, of the bladder in cases of chronic cystitis, &c. It is found in the neighbourhood of chronic ulcers of the stomach and duodenum, and around the liver in cirrhosis. In another class of cases it results from the irritation of new growths—*e.g.*, cancer of the liver, pancreas, stomach, &c.—or may be set up by contusion of any part of the abdominal wall.

The appearances met with in this form of peritonitis are very similar to those seen in the earlier stages of the acute form of the disease already described. The redness, however, is less marked, and the exudation of fluid is but slight. In these cases, moreover, there is a tendency to the development of fibrous adhesions, and, in place of the slight stickiness seen in the acute inflammation, there is a formation of fibrous tissue, which causes fixation of various viscera to one another or to the abdominal parietes. These fibrous bands are in some cases gradually elongated by the constant dragging of the attached tissues, and may thus at some future time be a cause of entanglement and strangulation of intestine in the manner already described in the chapter on Intestinal Obstruction.

In their mode of formation these bands do not differ from the fibrous tissue which forms the scar in the case of a wound; they are developed from the exuded leucocytes, and the blood-vessels which at first permeate them subsequently shrivel and disappear.

Chronic diffuse peritonitis may be the sequel of habitual engorgement of the serous membrane resulting from diseased conditions of the heart, lungs, or liver; it is also met with in cases of chronic interstitial nephritis. In cases of disseminated new growth—such, *e.g.*, as results sometimes from malignant ovarian disease—chronic peritonitis, with effusion of plastic lymph and the formation of adhesions, is of common occurrence. The changes met with in the localized form of the disease are seen in the diffuse variety spread over a larger area, but thickening of the serous membrane is more common in the diffuse than in the localized affection. Another and very important cause of chronic diffuse peritonitis is tubercle. In examples of this form of inflammation, the serous membrane becomes thickly studded with grey tubercles, which in some cases are present in such numbers as almost to completely cover the whole secreting surface. There is much matting of the intestinal coils, and exudation of a considerable amount of fluid; the mesenteric glands are commonly much enlarged, and often form masses of large size, to which the intestines become adherent. Tubercular peritonitis is usually part of a general tuberculosis.

CHAPTER LXII.

DEFORMITIES OF THE FACE AND SKULL.

HARE-LIP AND CLEFT PALATE.

THE causes of the deformities known as hare-lip and cleft palate are best explained by reference to the development of the face. The nose and mouth at first form one large cavity, which is subsequently partitioned off by growths from its roof and lateral boundaries. From the roof the "naso-frontal process" descends, and from the tissues forming it there are developed in the middle line the nose with its septum, the central portion of the lip, and the pre-maxillary bone, or that portion of the upper jaw which carries the incisor teeth. The naso-buccal cavity is thus separated into two lateral portions, which are subsequently represented on each side by the nostril and the antrum.

From the sides of the common cavity two other processes simultaneously develop, and grow inwards towards the middle line. These are named the "maxillary processes," or the "superior maxillary plates," and from them the cheeks, the sides of the lips, and the whole of the upper jaw, with the exception of the inter-maxillary bone, are formed, the cavity of the nose being now shut off from that of the mouth by the hard palate.

Both hare-lip and cleft palate result from a failure in the normal union between the naso-frontal and the

maxillary processes. If that part of the latter which forms the lateral portion of the lip fails to join on one side with the central portion of the lip, a "single hare-lip" results. If the failure occurs on both sides, the hare-lip is said to be double.

If the two maxillary plates do not fuse in the middle line of the palate posteriorly, the uvula is bifid or the soft palate cleft. If the failure to join is more complete, the hard palate is fissured, the fissure being in the middle line posteriorly, but running to one side or another of the inter-maxillary bone anteriorly, and thus is seen in front as a cleft between the lateral incisor and the canine tooth. In hare-lip the deformity may consist of nothing more than a slight notch on the mucous edge to one side of the middle line. More commonly, however, there is a greater failure, and the cleft passes through the whole depth of the lip and perhaps into the nostril. When the deformity is double, the central portion of the lip may be attached to the end of the nose.

In the slighter varieties of cleft palate, as already mentioned, the soft palate alone may be implicated, but in the more common form, where the cleft extends to the bony structures, the imperfection results in a communication between the nose and mouth, with consequent difficulty in swallowing, and sucking, combined with a nasal intonation of the voice. The reason why the cleft in the hard palate is in the middle line behind, but to one side in front, is that the posterior parts of the palatine processes are formed from the maxillary plates alone, whilst the arch is completed in front by the inter-maxillary bone. The fissure behind is thus a cleft between the two maxillary plates; in front, between the maxillary plate and the naso-frontal process, or that part of the latter called the inter-maxillary bone.

The nasal septum is usually attached below to the palatine process on the side opposite to that on which the deformity occurs. In some instances, however,

the cleft is double in front, the inter-maxillary bone not being united to the maxillæ on either side, in which case the nasal septum also is unattached except to the inter-maxillary bone.

It only remains to be added that in severe examples of cleft palate there is almost always hare-lip, and that, *vice versâ*, bad cases of the latter are usually complicated by cleft palate. The incisor teeth in cases of cleft palate are commonly undeveloped or imperfectly formed.

MENINGOCELE AND ENCEPHALOCELE.

Cerebral meningocele and encephalocele are protrusions of the cerebral membranes or of the brain itself through abnormal apertures in the skull. The most common site for such a protrusion is the occipital region, just behind the foramen magnum. In other cases the tumour appears at the anterior fontanelle; at the root of the nose, between the nasal and frontal bones; at the base of the skull, passing into the nares or pharynx; and, lastly, at the external angles of the orbit.

The membranes that are protruded are the dura mater and arachnoid, the cyst being distended by cerebro-spinal fluid. When the cyst contains brain matter, the latter is generally thrust out by distension of the ventricles with fluid. Meningocele is commonly associated with hydrocephalus.

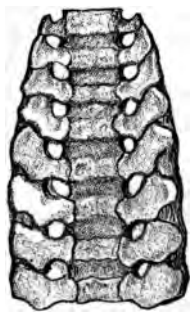
CHAPTER LXIII.

SPINA BIFIDA.

A SPINA BIFIDA is a congenital deformity of the spinal canal, with protrusion of a portion of its contents in the form of a cystic tumour.*

The bony deformity which is present in these cases consists of a deficiency in the laminæ and spines of one or more vertebræ, the spinal canal being thus left unclosed posteriorly. The laminæ may be merely stunted, but in bad cases are completely everted so as to stand out at right angles from the axis of the spinal column. As rare variations may be mentioned —(*a*) bony outgrowths from the posterior surface of the bodies of the vertebræ into the spinal canal, which may protrude through the centre of the cord itself; (*b*) cleavage of the body of a vertebra, and protrusion of the membranes anteriorly.

FIG. 129.



Portion of a Spine from a case of Cervical Spina Bifida, showing the absence of the laminæ and spinous processes.

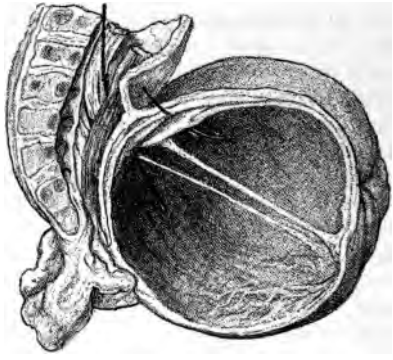
The common **position** of a spina bifida is the lumbo-sacral region,

* For a full account of the morbid appearances found in different cases of spina bifida, see a report of a committee of the Clinical Society in vol. xviii. of their "Reports," from which this chapter has been in great part compiled.

but it may occur in any part of the spine. In most cases some five or six of the vertebræ are deformed, but in exceptional instances the whole of the laminæ are deficient from the atlas downwards. Between these conditions all grades may be seen.

The **structure of the sac** and the composition of its contents differ in different specimens, and allow of a subdivision into three classes—first, meningocele; second, meningo-myelocele; third, syringo-myelocele.

FIG. 130.



Spina Bifida.—A Meningo-myelocele. One bristle has been passed from the sub-arachnoid space into the sac, and another has been placed beneath the spinal cord just before the latter becomes spread out on the upper part of the sac-wall. The filum terminale is stretched across the cavity of the sac, and is adherent to the most posterior part of the latter.

In **Meningocele** the sac is composed of dura mater and arachnoid, but contains neither the spinal cord nor any nerves, and is distended by the sub-arachnoid or cerebro-spinal fluid. It is doubtful whether one layer of the arachnoid alone is ever protruded, though this condition has been described. In such cases the sac would contain the arachnoid fluid.

In **Meningo-myelocele,** which is the most common form of spina bifida, the sac is formed by the dura mater and arachnoid, and contains cerebro-spinal fluid, with the spinal cord and its nerves. In lumbo-sacral spina bifida the **spinal cord** usually passes directly backwards, and the filum terminale is found adherent to the lower and posterior portion of the sac. In some specimens the cord becomes adherent to the upper part of the sac as soon as it enters it, and is spread out over, and incorporated with, the sac-wall itself. In cases of spina bifida in the dorsal or cervical regions the spinal cord passes through the sac, re-enters the spinal canal, and is found in its natural position in the lumbar region. In its passage through the sac it may be free, but is in some instances adherent to the posterior surface of the sac-wall, as in the lumbo-sacral class. In all cases of spina bifida the central canal of the cord is liable to be distended.

The **nerves** which arise from that part of the spinal cord which is included in the spina bifida are necessarily themselves within the cavity of the sac, the anterior and posterior roots being often easily differentiated and found separated from one another by a continuation of the ligamentum denticulatum. That part of the cord which is fused with the posterior portion of the sac-wall also gives off nerve-roots, and thus the latter appear to *originate* from the sac-wall itself, though they are often erroneously described as being *distributed* to it. (See Fig. 130.)

The **form** and **size** of the **sac** vary greatly. At birth it is usually small, not larger than a Tangerine orange, whilst in some cases the position of the spina bifida is marked by a depression instead of a swelling. During the first few days of life the sac increases with some rapidity, and has been seen to measure in adults as much as 27 inches round its base. Its shape is circular, and, although generally sessile, there is a marked constriction where it is connected with the trunk; in long-standing cases a pedicle is gradu-

ally formed. The most posterior portion of the sac, or the summit, frequently presents a median groove, furrow, or depression, to which the name of "the umbilicus" has been given. It is generally the result of the attachment of the spinal cord in this situation, and is caused by the unequal distension of the sac by its contained fluid. (See Fig. 131.) The central canal of the spinal cord has been seen to open at the bottom of the umbilicus. Occasionally, the sac is divided into

FIG. 131.

Spina Bifida, showing the umbilicus, or central depression, where the spinal cord is adherent to the sac-wall.

partial septa, and these also may produce depressions.

The coverings of the sac are rarely normal skin and subcutaneous tissue. In most cases the base is covered by skin, which gradually thins away over the umbilicus, so that the summit of the latter is covered by a thin layer of epidermis or by a membrane composed of the spinal membranes thinned and adherent cord.

Syringo-myelocele is a rare form of spina bifida in which the central canal of the cord is immensely dilated, forms the sac-cavity, the sac-wall being formed by the expanded spinal cord itself. At first

sight such a spina bifida might easily be mistaken for a simple meningocele, for no nerves traverse the sac-cavity. Close examination, however, shows that the nerves are contained in the substance of the sac-wall, being given off from the distended cord.

The coverings of a syringo-myelocele are of the same nature as those of a meningo-myelocele.

The congenital deficiency which results in the formation of any spina bifida consists in an imperfect development of the mesoblast on each side of the vertebral furrow from which the spinal meninges and the vertebral laminæ are normally produced. The mesoblast being deficient, these structures remain undeveloped in varying degrees.

The complications of spina bifida which are common are hydrocephalus, talipes, and paralysis of the rectum and bladder.

The termination of the majority of cases of spina bifida is death. This commonly results from the sac giving way, an event which is followed by myelitis or convulsions. Other children die in a marasmic condition, without any very definite lesions being present. In a small proportion of the meningo-myeloceles, and in a considerable number of the simple meningoceles, the sac gradually shrinks and a natural cure is effected.

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In support of this explanation the authors adduce various examples of fœtal malposition and pressure which seem quite sufficient to prove that the theories they advocate are supported by facts, and to establish such mechanical conditions as one of the causes of congenital club-foot, and probably the one which is most frequently operative.

Acquired talipes commonly results from disease of the spinal cord. This in some cases is irritative in its nature and produces spasm of certain muscles, which, at first by their vital contraction, and afterwards by their tendency to become permanently shortened, cause an active displacement of the foot; *e.g.*, spasm of the calf muscles will result in a drawing up of the heel, or "talipes equinus."

In another class of cases the lesion of the cord is of a destructive nature, the large nerve-cells in the anterior cornua being destroyed. This lesion, which is known as "anterior polio-myelitis," results in the condition called "infantile paralysis." The motor cells, which are the centres of nutrition for the motor nerves and the muscles they supply, being destroyed, the nervous and muscular fibres degenerate and atrophy, and deformities are produced both by shrinking of the paralysed muscles as well as in other cases by their stretching. Thus, if all the muscles of the leg are paralysed, the foot usually hangs in a helpless condition, with the toes pointed and somewhat inverted, and in this position, that of "talipes equino-varus," it may be permanently fixed in the course of months by the atrophy and shrinking of the calf-muscles. In other cases, where the calf-muscles are alone or chiefly affected, the extensors will support the foot, and the pressure on the sole in walking will tend to stretch the wasted soleus and gastrocnemius until the heel is permanently depressed and "talipes calcaneus" is produced. In some cases of polio-myelitis the paralysis passes off, but unless this improvement occurs within the first month or two

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in severe cases to the inner side of the astragalus, so that the articular surface of the head of the latter bone is unopposed in front, and a new articular facet is formed on the inner side of the head to articulate with the navicular bone in its altered position. In addition to this, Messrs. Parker and Shattock have noticed an extension backwards of the upper articular or trochlear surface and an undue obliquity of the neck of the astragalus.

In old cases of equino-varus, moreover, the bones on the inner side of the foot are compressed and undeveloped, the skin on the outer side forms a hard,

FIG. 132.

Dissection of a Foot with Talipes Equino-varus.

horny excrescence, and the muscles of the calf are small and feeble from the little use to which they are put, the movements of the ankle-joint being in these patients almost in abeyance.

TALIPES EQUINUS.

Talipes equinus consists in an inability to bring the sole of the foot up to a right angle with the leg. The

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out, or of nasal calculi or tumours. In other instances it is dependent on scrofula or syphilis, and more rarely on gout. The scrofulous catarrh is most common in children, and often results in much permanent thickening of the mucous membrane, with partial obstruction to respiration. In the cases dependent on syphilis the discharge is usually profuse and purulent, often foul smelling, and accompanied by ulceration; but all cases are not so severe.

Purulent catarrh, or ozæna.—The term ozæna is used to designate a condition in which there is a discharge of pus from the nostrils accompanied by a peculiarly foul odour. The discharge is often bloody, and may be mucoid rather than purulent; in all cases it is fetid.

Ozæna results from various forms of ulceration, and may be of traumatic, scrofulous, or syphilitic origin. Scrofulous ulceration is most common in children, and especially in those who exhibit some other signs of struma. The ulcers are small, but multiple, are usually covered by a scab, and secrete the thin watery pus characteristic of scrofulous inflammations in other parts. In some cases the ulcers are of a lupoid nature. Syphilitic ulcers are sometimes seen in the subjects of congenital syphilis, but are usually met with in adults; they also are multiple, and may be either superficial or deep. The ulcers are larger and less numerous than those of scrofulous origin.

In both syphilitic and scrofulous ulceration the subjacent bone may be diseased, and either caries or necrosis may complicate the case. In some instances there is extensive destruction of the osseous framework—a condition which is most common in syphilitic patients. In cases of ozæna following injury, it will generally be found that there is some necrosis, and it is to the presence of the dead bone that the continuance of the discharge is to be attributed. In other cases the ozæna is dependent upon the introduction and

retention of foreign bodies, or on the presence of nasal calculi. These latter bodies, called also **rhinolithes,** are most commonly found in the inferior meatus, and are often formed around a foreign body. They consist chiefly of phosphates and carbonates of lime and magnesia.

TUMOURS OF THE NOSTRILS.

The commonest tumours of the nostrils are **mucous polypi.** These growths occur for the most part in young adults, and in some cases follow chronic coryza. They are almost invariably multiple and pedunculated, and vary in size from a pea to a raisin. In colour they are pink or red, and have a translucent appearance. Their surface is very smooth and slippery, and their consistence soft and elastic. Microscopically examined, they are found to be composed of myxomatous tissue, or of very soft and succulent fibrous tissue, in the meshes of which there is a mucoid fluid; they are covered by ciliated epithelium such as is normally met with in the nares. After long exposure near the nasal orifices, the most dependent parts of these growths become more firm, fibrous, and white. The common situation for these growths is the external wall of the nostril, where they are commonly attached to the middle turbinate bone, but they are also found on the superior and inferior turbinate bones, as well as on the mucous membrane covering the roof of the nose; they are very rarely attached to the septum nasi.

The irritation caused by the presence of these growths usually sets up a nasal catarrh, which, in its turn, probably promotes the growth of polypi, for there can be no doubt that the longer polypi are left untreated the more numerous do they become. The smaller and more recent ones occupy the upper parts of the nasal cavities, and do not develop or come into view until the older and more superficial ones have been removed. In all cases polypi cause

an unpleasant nasal intonation of the voice, and, when numerous and large, may cause bulging and deformity of the nose. However large they grow, or however long they remain, they scarcely ever bleed.

Fibrous and sarcomatous polypi.—These growths are not so common as are the mucous polypi; they tend to grow especially from the roof of the nose and the septum. They occur at all ages, but are, perhaps, more common in the young. They usually originate in the periosteum, and not in the mucous membrane, as do the simple myxomata. They vary in size, but often grow so large that the nostril is no longer able to contain them, and they protrude into the pharynx; when occupying this position, they are known as naso-pharyngeal polypi. Their surface is in some case smooth, but in others papillated or spongy. On microscopical examination, they are found to consist either of simple fibrous tissue or else of a fibrous matrix containing connective-tissue cells of various shapes. In some cases the whole growth is sarcomatous, and composed entirely of cells.

Growths such as these grow more quickly than do mucous polypi, but those composed of pure fibrous tissue increase more slowly than the pure sarcomata. As they develop, they tend to extend into neighbouring cavities, and sometimes infiltrate the surrounding tissues, as do malignant growths elsewhere. They may thus produce considerable deformity. Hæmorrhage is a common symptom, and may be very excessive. If removed, all growths of this class show a great tendency to recur, and, although this is most marked in the tumours of sarcomatous structure, it is seen also in those composed of simple fibrous tissue.

Tumours of the nostrils other than those above described are of rare occurrence, but epitheliomata, osteomata, and enchondromata growing from the nasal *cartilages* have occasionally been observed.

CHAPTER LVII.

DISEASES OF THE ŒSOPHAGUS.

THE œsophagus is very rarely the seat of simple inflammation or ulceration. Either of these conditions may, however, be set up by injury caused by swallowing rough or sharp substances, or else by drinking caustic acids or alkalies. In diphtheria, also, the ulceration and formation of membrane frequently extend to the œsophagus.

Slight inflammations or ulcerations clear up without inducing any important change, but in some cases of poisoning by corrosive liquids the scarring which ensues is sufficient to cause a diminution in the calibre of the tube, and so produce a **fibrous stricture.**

These, like strictures of other mucous passages, are very liable to continue to contract, and sometimes cause such narrowing that the passage of food becomes impossible, and death from starvation ensues. In cases such as these, the œsophagus above the strictured portion is usually dilated and its walls often thickened. This condition readily explains the fact that food is sometimes apparently swallowed, and is after a time regurgitated, having merely gone as far as the pouch above the stricture. In other cases, again, the mucous lining of the pouched portion is inflamed or ulcerated, with the resulting discharge of much mucus, which is constantly being "hawked up" by the patient.

Cancerous stricture is unfortunately much more frequent than simple fibrous narrowing, and is espe-

cially liable to occur in old people. It is more often met with in men than in women. The most common variety of malignant growth of the œsophagus is certainly epithelioma, but scirrhous carcinoma is by no means rare, and I have myself seen four or five instances of it. Colloid and medullary cancers are much more uncommon.

Epithelioma is especially frequent in the upper part of the œsophagus, and is met with just behind the cricoid cartilage more often than in any other situation. In some cases the new growth extends into the lumen of the tube, and thus obstructs the passage of food, but more frequently it infiltrates the walls in their whole circumference, and, gradually causing an induration and shrinking of the latter, results in the formation of an "annular stricture." In other instances, again, the growth extends along several inches of the tube, and so causes a "tubular stricture." In any case the mucous membrane soon becomes ulcerated, and a foul, sloughing, and bleeding surface is produced. The other most common sites for epithelioma are the lower portion of the œsophagus just above the cardiac orifice of the stomach, and that part of the tube opposite to the bifurcation of the trachea.

Scirrhous carcinoma is not so common in the upper part of the œsophagus as lower down, and is more often seen in that part of the tube which is within the thorax than that which is in the neck. The growth presents the characteristic appearance of similar growths elsewhere, being extremely hard, causing much contraction, and developing with comparative slowness.

Both epithelioma and scirrhus of the œsophagus terminate fatally, and each in much the same manner. Death may be finally brought about in one of several ways. In some cases the inability to swallow induces starvation, but in many more the growth extends to, and opens, the trachea or bronchi, sets up septic

broncho-pneumonia by the passage of the foul discharge into the air-passages, and sometimes leads to an almost gangrenous condition of the lung. More rarely the pericardium is involved, and acute pericarditis terminates the case. In other patients, again, death appears to result rather from blood-poisoning than anything else, and the source of this is not difficult to find when we consider the extremely foul surface from which discharge is constantly passing into the food-passages or is being directly absorbed by the lymphatics.

If a patient who has died of cancer of the œsophagus be examined post-mortem, it is by no means infrequent to find no glandular enlargement and no secondary growths; but in other cases, the glands in the neck or the thorax are infiltrated, and in some the liver, kidneys, or lungs are similarly affected.

Sarcomatous tumours of the œsophagus are very rare, and do not require any special description.

CHAPTER LVIII.

HERNIA.

A HERNIA is an abnormal protrusion of some of the contents of the abdominal cavity. This protrusion most often occurs at one of the places where the passage of various structures from the abdomen to the lower extremities or genital regions provides apertures which may allow, in addition, the transit of some of the abdominal viscera.

A hernia is described as being composed of a **sac** and **contents.** The **sac** consists of peritoneum, and, except in the case of congenital malformations, is formed by a protrusion of a portion of the parietal peritoneum in front of the viscus which is escaping from the abdomen. At first this sac has no independent existence, *i.e.*, if the contents are returned into the peritoneal cavity, the bulging peritoneum will again become smoothed out. This, however, is only in the very earliest stages of the hernia, for after a short time the sac contracts adhesions to the tissues amongst which it has been thrust, and can no longer be reduced. And not only does the sac become adherent to the tissues around it, but the folds into which the peritoneum is thrown at the orifice through which it is extruded become adherent to one another; for it is evident that, if the peritoneum covering the internal abdominal ring, for example, be thrust down into the scrotum, it will be thrown into numerous folds where it passes through the ring, and it is

etween these folds that adhesions shortly form. his narrowed part of the sac which lies close to the bdominal cavity is named the **neck,** whilst the ower part, which is much more capacious, is called he **fundus.** The sac thus becomes somewhat flask-haped, and the neck is in time still further narrowed.

FIG. 111.

The Sac of an Inguinal Hernia, showing the constriction and fibrous ring at the neck.

or, as the result of the pressure of its contents ithin, and of the abdominal rings without, the peri-oneum and sub-peritoneal tissues become matted and hickened by fibrous tissue, and a more or less dense brous ring, with occasionally some unstriped muscle, s formed at the neck. The peritoneum forming the undus also undergoes a change of texture. In most erniæ (*e.g.*, inguinal and femoral) it becomes slightly hickened; whilst in others, notably in the umbilical ariety, the peritoneum forming the sac is so thinned hat in places it entirely disappears, and the sac is hen called "incomplete." In other herniæ, again, he sac is incomplete from the first, for a viscus hich is not entirely covered by peritoneum, such as he bladder, or in some cases the cæcum, may escape om the abdominal cavity without pushing a complete

covering of peritoneum in front of it. In such herniæ the protruded viscera rapidly become adherent to the tissues amongst which they lie, and are consequently irreducible.

The **contents** of a hernial sac consist of a little fluid secreted by the serous surface, with, usually, either intestine or omentum; but almost any of the abdominal viscera may herniate, those only being excepted, which, like the pancreas, are firmly fixed. A hernia containing omentum is named an **epiplocele**; one containing intestine, an **enterocele.**

The **condition of the contents** varies. When the latter can be returned within the peritoneal cavity, the hernia is said to be **reducible,** whilst if such is not the case it is called **irreducible.** In some cases, usually as the result of injury, the hernia becomes **inflamed**; and in others, fæces, accumulating in the gut which is in the sac, cause the hernia to increase in size and to become for the time irreducible —a condition to which the term **obstructed** or **incarcerated** is applied.

Lastly, the hernia may be **strangulated,** but before describing this it is necessary to say a few words on the subject of irreducible herniæ.

As already mentioned, some herniæ are irreducible from the time of their formation, a circumstance which is dependent on the incompleteness of their sac; whilst others, which are at first reducible, become irreducible through the thinning away of the peritoneum forming the sac, and the subsequent adhesion of the contents to the tissues with which they are thus brought into contact. The commonest cause of irreducibility, however, is thickening of the protruded omentum, for, on account of the friction and pressure to which a herniated piece of omentum is subjected, it soon becomes greatly indurated and increased in size by the formation in it of fibrous tissue, and is consequently after a time unable to return by the aperture through which it formerly escaped. In other cases,

again, this thickening is accompanied by the contraction of adhesions to the sac-wall or to some of the contained intestine, and thus a further obstacle is offered to reduction. Lastly, it has been already mentioned that, when the intestine in a hernial sac becomes blocked by fæces, it is for the time irreducible.

FIG. 112.

A Hernial Sac, containing a mass of thickened omentum which has become adherent to the posterior wall of the sac.

In a **strangulated** hernia, not only are the contents irreducible, but they are so tightly constricted that the *circulation of the blood through them is interfered with;* it is to the latter condition that by far the greater importance is to be attached. In some cases, and especially those where the hernia is suddenly caused by exertion or injury, the contents, as soon as extruded, are so tightly gripped by the margins of the aperture through which they are thrust that strangulation at once ensues. This is by no means a common occurrence, and it is usually only after existing for some time that herniæ become strangulated. At *first sight* this is not altogether easy

of explanation, for it does not appear evident why a hernia which has frequently descended before, and has always hitherto been reducible, should suddenly become so tightly gripped as to cause its irreducibility and constriction. And it may be easily seen that these conditions cannot be due to any sudden alteration in the size of the rings or the neck of the sac, for neither of these possesses the requisite amount of contractility. The true cause of the strangulation is probably to be found in the descent of a greater quantity of intestine or omentum than has before descended, and the consequently greater pressure to which either is subjected at the aperture through which it passes. This is borne out by the evidence of patients, who often state that on the occasion of strangulation the hernia has descended in greater bulk than previously. The descent may be due either to exertion or to excessive movement of the intestines, as in colic or diarrhœa.

The position of the constriction relative to the contents of the sac differs in different cases. In some it is outside the sac—*e.g.*, at the external or internal abdominal rings, at Hey's or Gimbernat's ligaments, &c. In others it is the fibrous thickening already described as forming the neck of the sac which is the constricting element; whilst in a few and rare instances the coils of intestine are encircled by bands of adhesion formed within the sac itself, in the manner already mentioned in connection with irreducible herniæ.

If intestine be strangulated, it is the passage of venous blood which is first interfered with, and the gut becomes congested. The congestion in its turn causes swelling, and thus increases the tightness of the constriction. The gut becomes of a dark plum colour, very tense and shiny, and at the same time the fluid in the sac quickly increases in quantity and becomes blood-stained, being exuded from the serous surface of the imprisoned intestine. In many cases the distended vessels relieve themselves by rupturing into the cavity

of the gut, the blood being subsequently passed *per anum* if the strangulation be relieved. After a time, not only is the venous circulation obstructed, but, as the tightness of the constriction increases, the flow of blood through the arteries is arrested, and gangrene of the imprisoned intestine shortly ensues. In such a case, the colour of the gut changes to an ashen grey, the surface becomes wrinkled, its shiny appearance is lost, and the peritoneum can be peeled off; finally, rupture results, and fæces escape into the sac. Usually, the patient dies by the time such a stage has been reached, death being due to exhaustion and collapse resulting from the pain and vomiting which accompany strangulation. In very rare instances the patient survives yet longer, and, if such be the case, suppuration and sloughing of the sac and of the tissues around it will follow, and fæces will finally be discharged through the skin. In some cases peritonitis supervenes, being caused by an extension of inflammation from the sac; but in other cases, even when gangrene ensues, the extravasation of fæces into the peritoneal cavity, and the spread of inflammation to the serous membrane, are arrested by adhesion between the strangulated gut and the neck of the sac.

But not only does the constriction of the gut tend to cause sloughing of the part beyond the stricture; it also causes ulceration of the intestine at the seat of stricture itself. This is a fact of the greatest practical importance, for it may happen that the state of the knuckle of intestine which is found in the sac during the operation of herniotomy is sufficiently good, and free from appearance of sloughing to warrant its return after division of the stricture, but that, nevertheless, the intestine *where gripped* is at one small spot already ulcerated or sloughing. If this condition is not ascertained by drawing down the gut and examining it before effecting its reduction, nothing can prevent subsequent fæcal extravasation and diffuse peritonitis. (See *Fig.* 113.)

In cases where an opportunity is afforded of making a post-mortem examination of a case of strangulated hernia which has not been relieved by operation, the difference in the appearance of the intestine above and below the seat of strangulation is very marked, for the coils above are greatly distended and congested, and in extreme cases, where the distension has been excessive, the peritoneal coat splits; the coils below the stricture are, on the contrary, collapsed and pale.

FIG. 113.

Loop of Intestine from a case of Strangulated Femoral Hernia. A small oval ulcer marks the place where the gut has been constricted by Gimbernat's ligament. The large piece of intestine to the right is a portion of the dilated intestine above the seat of strangulation; the small piece of intestine to the left was below the stricture.

In those cases where the gut has sloughed and all the fæces continue to be discharged through the skin, the patient is said to have an **artificial anus.** When most of the fæces are passed by the anus and but little fæcal matter escapes by the opening, the term **fæcal fistula** is employed. If only a small portion of the whole circumference of the gut has been destroyed, such an opening may gradually contract and finally close, but when the sloughing has

been of greater extent so fortunate a conclusion is not to be expected. In consequence of the pressure exercised by the abdominal contents on the distal portions of the intestine, the latter remains collapsed and does not permit of the passage of fæces, whilst, after a time, a further obstacle is interposed in the form of a protrusion of a fold or spur of mucous membrane from between the apertures of the upper and lower pieces of intestine. This acts as a valve, and effectually prevents the passage of fæces by the natural channel, and, until it has been removed by operation, the artificial anus remains patent.

The causes of herniæ are either congenital or acquired. Of the former, the chief predisposing cause is a failure of the normal process of closure of the processes of peritoneum which in fœtal life extend into the scrotum and through the umbilical aperture. The consequent weakness of the abdominal wall is in some instances supplemented by an undue length of the mesentery, which allows the intestines to hang more heavily than is natural against the parietes. In a considerable percentage of such cases, the hernial tendency appears to be hereditary.

In later life the mesentery and omentum may acquire an undue length through stretching, consequent upon the accumulation of fat in their substance, and, from the same cause, the tension of the abdominal contents may be considerably increased. It is thus that umbilical herniæ, more especially, are found in people over middle age who have recently become obese. The reverse condition also, namely, wasting and loss of flesh, tends to the development of herniæ, although in a different manner. Here, the abdominal contents become prone to extrusion on account of the removal of the fat and cellular tissue which normally occupy the apertures of exit from the abdomen. It will therefore be seen that both emaciation and obesity are causes of herniæ in adult life, and *it may be added* that anything which induces

a loss of muscular tone, any condition of debility, is favourable to the production of a hernia. For, normally, the muscular walls of the abdomen by their constant contraction both support the contained viscera and promote the closure of all apertures which naturally exist.

As directly exciting causes of herniæ may be mentioned wounds and lacerations of the abdominal walls. Thus, it is common for a hernial protrusion to follow the operations of ligature of the iliac vessels, abdominal section, &c., as well as accidental injuries of various kinds. Suppuration also tends to produce the same result.

VARIETIES OF HERNIÆ.

It is not possible to devote sufficient space in the present work to a description of the anatomy of the parts concerned in the various forms of herniæ; for such details, works on anatomy should be consulted. It is, however, desirable to point out very briefly the common positions of hernial protrusions, as well as the main points worthy of notice in connection with the probable seat of strangulation and the mode of formation of the sac.

In **inguinal** hernia, the protrusion passes either through the whole length of the inguinal canal (an oblique hernia) or directly through the external abdominal ring (a direct hernia) and thence into the scrotum or labium. The sac of such a hernia may be (*a*) congenital or (*b*) acquired. Of the former there are several varieties.

Normally, the descent of the testis into the scrotum is followed by a closure of the process of peritoneum which the organ carries with it from the abdominal wall. This closure commences, above, at about the level of the external abdominal ring, and, below, immediately above the testis. The intervening or "*funicular*" portion of the tunica vaginalis is subsequently gradually obliterated. If this closure

does not occur at all, then the cavity of the tunica vaginalis testis communicates directly with the peritoneal cavity; and if a hernia descends, which is by no means necessarily the case, it will pass into a sac already formed, namely, the tunica vaginalis testis. Such a hernia is named "**congenital.**"

In other cases the tunica vaginalis testis becomes shut off from the general peritoneal cavity by adhesion

FIG. 114.

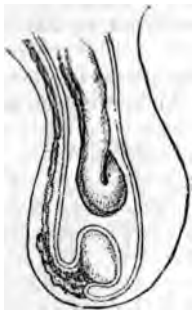


Diagram of a Congenital Inguinal Hernia. The loop of gut is within the tunica vaginalis testis.

FIG. 115.

Diagram of a Funicular Hernia. The loop of gut is in the unobliterated funicular portion of the tunica vaginalis, which has been separated from the testicular portion.

immediately above the testis, as already mentioned, but instead of the funicular portion of the peritoneal sac being obliterated, and closure occurring at the external ring, the funicular portion remains open and ready to receive any viscus that subsequently protrudes. To such a hernia the name of "**funicular**" is applied, for the sac is formed of the unobliterated "funicular" portion of the tunica vaginalis, the testis itself being separated from the hernial sac by a thin septum.

In yet other cases both the funicular and testicular portions of the tunica vaginalis remain unobliterated

and continuous with one another, but their cavity is separated from the general peritoneal cavity by the closure already mentioned, which normally occurs at the external abdominal ring. If a hernia now develop, the hernial sac is usually formed by a protrusion of a fresh portion of peritoneum from the neighbourhood of the internal abdominal ring, the sac being thus an acquired one. In such a case the hernial sac is liable to be protruded behind the unobliterated funicular portion of the tunica vaginalis, and, as it increases in size, tends to bulge into the cavity of the latter. A hernia with such a relation to the tunica vaginalis is named "**infantile.**"

Another variety of hernia is generally described which is said to be developed in connection with a

FIG. 116.

Diagram of an Infantile Hernia. The loop of gut is behind the unobliterated funicular portion of the tunica vaginalis, and is contained within a sac formed by a process of peritoneum pushed down from the neighbourhood of the internal abdominal ring.

FIG. 117.

Diagram of an Encysted Hernia. The gut is contained within a sac formed by an invagination of the upper part of the unobliterated funicular portion of the tunica vaginalis.

precisely similar abnormal condition of the tunica vaginalis to that last described. It is named "**encysted,**" and the sac is said to be formed by a

yielding of the adhesions at the point of closure of the funicular portion opposite the external ring. In this form of hernia the sac is invaginated into the unobliterated funicular portion, and is not placed completely behind the latter as in the infantile variety; much doubt, however, has recently been cast on the existence of true encysted herniæ by the investigations of Mr. Lockwood. Reference to the accompanying diagrams will render these various forms of herniæ more intelligible.

Interstitial hernia.—This form of hernia, called also "intra-parietal" and "hernie en bissac," is characterized by the presence of offshoots or pouches of the sac, which extend amongst the structures composing the abdominal wall. Thus, a sac may meet with some obstruction at the external abdominal ring, and may then extend either upwards, outwards, or inwards *behind* the aponeurosis of the external oblique. In other cases it passes through the external ring, but, meeting with difficulty in its further passage to the scrotum, extends between the skin and external oblique, and forms a swelling parallel to Poupart's ligament. Much more rarely the sac extends into the iliac fossa and passes between the iliac fascia and the peritoneum.

Acquired inguinal hernia.—In the case of an ordinary acquired inguinal hernia there is no abnormal condition of the tunica vaginalis to complicate matters, and the sac is formed in the manner already described in an earlier part of the present chapter. When an inguinal hernia becomes strangulated, the seat of constriction may be either the external or internal abdominal ring or the neck of the sac, but it should be remembered that when the sac is of congenital origin its neck is almost always the cause of the constriction.

In **femoral** herniæ the protrusion takes place at the crural ring, traverses the crural canal, and subsequently appears at the saphenous opening. The sac

is always an acquired one, and is not so capacious as is that of an inguinal hernia. The contents are usually part of the ileum with more or less omentum. If strangulation occurs, the seat of constriction is usually outside the sac, being at Gimbernat's or Hey's ligament or the deep crural arch. On account of the sharpness of these bands of ligament, the imprisoned gut ulcerates and sloughs more rapidly than is the case in inguinal herniæ, and it is well known to all surgeons that, on this account, the mortality after herniotomy for femoral hernia is greater than in the case of inguinal ruptures.

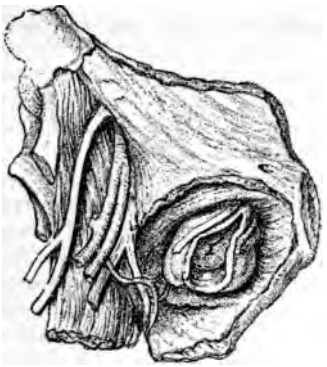
In **umbilical** hernia the abdominal viscera escape either through the umbilical ring itself or else through the linea alba in its immediate neighbourhood. This form of rupture is common in new-born children, and in them is readily curable by the application of slight pressure. When occurring in adult life, it is met with most commonly in very stout people with much intra-abdominal fat. In these the sac is usually of extreme tenuity, and is often gradually thinned away to such an extent that in places it becomes incomplete, the contents contracting adhesions to the surrounding parts and becoming irreducible. These contents almost always comprise omentum and jejunum, but in some cases the transverse colon is extruded. If strangulated, the seat of constriction is the aperture of exit in the linea alba, or adhesions formed by the omentum within the sac.

In **obturator** hernia the sac is always acquired, and is protruded through the upper part of the obturator foramen in company with the vessels and nerves of the same name. This variety of hernia is most common in thin, elderly women; the sac is always small, but sometimes causes pressure on, and pain in the course of, the obturator nerve. Strangulation is not common, and, when it occurs, the constriction is usually outside the sac and not very acute. (See Fig. 118.)

A **ventral** hernia is one in which the sac is formed

by a protrusion of peritoneum at a part of the abdominal wall in which normally no aperture exists. Such herniæ sometimes occur in the middle line between the recti muscles in women who have had prolonged and difficult labours, but are more often the sequel of wounds of the abdominal wall followed by formation of a weak and yielding scar. They are very rarely strangulated.

FIG. 118.



An Obturator Hernia. The sac protrudes through the upper part of the thyroid foramen, and the obturator vessels and nerve are stretched over its anterior surface.

Perineal and **sciatic** herniæ are extremely rare. In the former, the protrusion takes place between the anterior fibres of the levator ani; in the latter, through the sciatic notch, beneath the gluteus maximus.

Diaphragmatic hernia is either due to a congenital defect in the diaphragm or to injury. In the former case, the congenital aperture is almost invariably situated in the left half of the muscle; in the latter, it may be situated in any portion. In this form of hernia there is no true sac, the viscera escaping into the pleura, and, more rarely, into the pericardium. The viscera which escape are usually the stomach,

colon, and small intestine. Strangulation is rare, but is not unknown.

Littré's hernia is the term applied to either a strangulation of a Meckel's diverticulum or to the strangulation of a portion only of the whole circumference of a knuckle of intestine. To this latter condition the name of "partial enterocele" has more recently been given. Both these varieties of hernia are of interest, for although in neither of them is the whole calibre of the gut mechanically obstructed, nevertheless all the symptoms of strangulation are present. It is thus evident that the vomiting and constipation which accompany strangulation are not the result of simple mechanical obstruction, but are caused reflexly by the injury to, and irritation of, the constricted peritoneum.

In connection with the subject of hernia may be mentioned **protrusions of sub-peritoneal fat** through the linea alba. They usually occur about midway between the umbilicus and the ensiform cartilage, and form soft, partially reducible swellings, about the size of a walnut or a little larger, and increasing during any straining movements or in the act of coughing. Sometimes they can be reduced and the aperture of exit in the linea alba can be clearly defined, but in all cases where they have existed more than a few months they become irreducible. I have seen these swellings in both men and women above middle age, and have had opportunities of examining two of them post-mortem. They are liable to be mistaken for true herniæ, but the mistake is of little consequence, for they are well treated by the application of a truss.

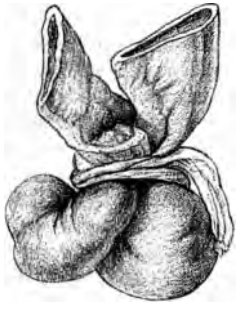
CHAPTER LIX.

INTESTINAL OBSTRUCTION.

This term is applied to all the various forms of mechanical obstruction of the intestines within the abdomen, as opposed to the external herniæ which protrude through the abdominal walls.

The following are the chief varieties of intestinal obstruction:—Internal herniæ; volvulus; intussusception; obstruction by foreign bodies and fæcal accumulation; stricture; tumours of the intestine; pressure on the bowel from without by tumours, &c.; chronic peritonitis.

Fig. 119.



An Internal Hernia. A loop of small intestine is strangulated by a band of adhesions.

The term **internal hernia** is applied to cases in which intestine has become constricted by bands of adhesions or of omentum, or by slipping through apertures in the omentum or mesentery or into such normal openings as the foramen of Winslow and the inter-sigmoid fossa. Bands of adhesion are formed as the result of peritonitis, and are most common in the right iliac fossa, though they may occur in any part of the abdomen. Portions of omentum may also become adherent from peritonitis or by inclusion in

the sac of an irreducible hernia. In other cases bands are formed in connection with a persistent Meckel's diverticulum. This latter, when present, is a pouch or offshoot of the small intestine, formed by an undue persistence and development of the vitelline duct. It is situated about 2 feet above the ileo-cæcal valve, and varies in length from an inch to a foot. In some cases it is adherent to the umbilicus from birth; in others, it contracts adhesions to some other part of the abdominal parietes; whilst very frequently it remains free and movable in the abdominal cavity. When adherent, coils of intestine may be caught around or compressed by it; whilst in some few instances, when free, it has been known to knot itself round the mesenteric attachment of a knuckle of bowel. Strangulation of intestine from slipping through apertures in the omentum, into the foramen of Winslow, &c., is of very rare occurrence, and does not require further comment.

Volvulus, or twisting of the intestine, is most often seen in the sigmoid flexure, but is nowhere common. In cases where the sigmoid flexure is unusually voluminous, large coils of the gut sometimes protrude almost at right angles from the course of the descending colon. The size of these coils is in most cases acquired, and appears to be the result of chronic constipation; in such cases the meso-colon is also longer than natural. If this part of the bowel is distended by fæces, it may happen that these coils become doubled over by the weight of their contents, and so twisted upon their mesenteric axis, and kinked, that both the passage of fæces and the free circulation of blood in the mesenteric vessels are interfered with, and strangulation results. In such cases gangrene and peritonitis rapidly ensue. Much more rarely a similar form of volvulus is found in the ascending colon, whilst the same portion of bowel has also been seen twisted around its own longitudinal axis. The cæcum also, especially when imperfectly developed, has been known to be the seat of a twist. Volvulus

of the small intestine is met with only in connection with previous peritonitis and adhesion of loops of intestine; it is extremely rare.

Intussusception.—In intussusception one portion of the intestinal tube is invaginated into the lumen of that portion of intestine with which it is immediately continuous below. A complete intussusception consists of three cylinders or rings of bowel. The innermost of these is named the entering layer; the middle, the returning layer; and the external, the sheath. Intussusception is most common in children, and

FIG. 120.

An Intussusception. The sheath has been laid open so as to show the intussuscepted portion.

usually originates at the junction of the ileum with the cæcum. In this situation the ileum, with the ileo-cæcal valve, is pushed into the more capacious cæcum. If the intussusception now continues to increase, it does so at the expense of the colon, more and more of which is rolled in by the constant and excessive vermicular contraction of the intestines. It thus happens that the apex, or presenting part, of the invaginated bowel, or the "intussusceptum," throughout the development of the affection always consists of the same *portion of* gut which originally became

intussuscepted, namely, the ileum and the ileo-cæcal valve, and thus in some cases the latter may present at the orifice of the anus. This form of intussusception is named **ileo-cæcal,** but another and much more rare form, named **ileo-colic,** is met with, in which the ileum becomes inverted *through* the ileo-cæcal valve, and the intussusceptum increases by protrusion of additional portions of ileum. Intussusceptions are also found in the small intestine and in the descending colon and sigmoid flexure, but seldom attain a large size. All true intussusceptions may easily be distinguished from similar invaginations which are formed sometimes during the irregular movements of the intestine which occur not uncommonly just before death. These latter intussusceptions are always small, frequently multiple, easily reduced, and the gut is not congested.

If an intussusception remain unreduced, congestion and subsequent sloughing of the imprisoned bowel is apt to ensue. In some cases an intussusception persists for a considerable time without serious mischief resulting, but such instances are comparatively rare, and much more commonly the circulation in the intussuscepted gut is quickly interfered with by the traction on its mesentery. The intussusceptum swells from venous engorgement, and very soon blood escapes from the distended vessels into the interior of the intestine, as well as into the wall of the gut itself. The swelling causes, in its turn, a greater constriction of the intussusceptum where it enters the sheath, the arterial circulation is arrested, and gangrene results. In its early stages an intussusception may be reduced, but later on this becomes impossible. The irreducibility is in great part the result of the swelling already mentioned, but, in addition, adhesions soon form between the sheath and the returning layer, and fix the latter in its abnormal position. In almost all cases there is an extension of inflammation from the inflamed or sloughing intestine to the neighbouring

peritoneum, and peritonitis results; whilst sometimes the sheath itself becomes ulcerated, or even gangrenous. Spontaneous cure is less rare than is generally supposed; the gangrenous intussusceptum is cast off as a slough, and the patient recovers with an intestine which is shortened in proportion to the length of that piece which has sloughed, the continuity of the canal being established by the adhesions which form between the sheath and the returning layer.

It is not easy to assign a definite cause to each individual case of intussusception, but it is probable that all owe their origin to irregular and excessive contractions of the bowel, such as occur in colic, or result from the presence of any hard or foreign body in the intestine. In some cases the trouble may be traced to the presence of a polypus, which, being gripped by the bowel below its seat of attachment, is drawn in, together with the gut from which it grows, during peristalsis.

Obstruction by foreign bodies and fæcal accumulations.—It is not often that intestinal obstruction results from the presence of foreign bodies, unless in this category hardened fæces be included. The various foreign bodies which are so frequently swallowed are seldom of sufficient size to block the intestine, whilst yet small enough to safely pass the œsophagus and stomach. They may, it is true, lodge in the cæcum or some other part of the alimentary tract, and cause grave trouble by setting up ulceration, with the subsequent formation of fæcal abscesses or fistulæ, or may induce peritonitis; yet, withal, they seldom entirely obstruct the calibre of the intestine. A more frequent cause of obstruction is a gall-stone, and it is probable that, when it is of sufficient size to become impacted, it has gained the cavity of the bowel rather by ulcerating from the gall-bladder into the duodenum than by passing along the gall-duct, for it is difficult to conceive that a stone which *would traverse* the latter could block the gut.

Intestinal calculi, or enterolithes, are of rare occurrence, they are usually composed of phosphatic deposits formed around some foreign body, or of masses of hair or fibre; these latter are generally met with in hysterical subjects or lunatics. In other cases the calculi are composed of vegetable matter, or of masses of insoluble salts, such as magnesia, which have been taken medicinally. Any of these forms of enterolithes may attain great size, and completely obstruct the bowel.

Fæcal accumulation is the result of long-continued and neglected constipation, and is seldom seen in early life. The accumulation is necessarily gradual, and is most common in the cæcum, sigmoid flexure, and rectum. In such cases the intestine, which is already feeble and slow to contract, becomes still more paralysed by the distension and pressure of the contained mass, and, should the condition remain unrelieved, complete cessation of all peristalsis results. In addition to the mechanical blocking of the bowel, the fæcal mass, which becomes harder and dryer the longer it is retained, causes inflammation and ulceration of the intestine, and, subsequently, localized chronic peritonitis, the gut above the obstruction becoming also immensely distended. In other cases fæcal masses not large enough to occlude the intestine remain in the cæcum and keep up persistent irritation, perhaps for months.

Stricture of the intestine.—Except in the rectum, stricture is rare, and the forms of narrowing in this part of the bowel will be dealt with more fully in the chapter on Diseases of the Rectum. The simple strictures of the intestines are, like those of other mucous canals, caused by the contraction of scar tissue at the seat of previous ulceration, those ulcers which are most often followed by such contraction being the dysenteric, the catarrhal, the tubercular, and the syphilitic. The strictures caused by the two first of these are most common in the large

intestine; those by the two latter, in the lower part of the ileum and the cæcum.

Tumours of the intestine (not including the rectum).—Both innocent and malignant tumours are met with in the intestine, the latter being unfortunately the more common.

Of the innocent growths, the simple glandular polypus is of most frequent occurrence. It is seen in children, and is sometimes multiple. Its common site is the lower part of the ileum and the colon. It is seldom large enough to obstruct the bowel, but, as already mentioned, may cause intussusception. Fibrous, nævoid, and fatty growths are very rare.

Malignant tumours are much more common in the large than in the small intestine. They are almost invariably carcinomatous, and frequently belong to that variety of malignant growth to which the name of adenoid cancer has been given. These growths become more common the nearer we approach to the anus, but are more frequent in the cæcum than in the ascending colon. They cause much induration and narrowing of the intestine, with the formation of a so-called "cancerous stricture." The growths themselves ulcerate, and may furnish a discharge of blood-stained and foul fluid from the anus. Above the stricture the gut becomes dilated, inflamed, and often ulcerated, so that perforation of the bowel and acute purulent peritonitis frequently induce a fatal termination. On post-mortem examination, it is by no means rare to find no secondary growths in any of the viscera, and in a considerable number of cases there is no glandular affection. In some cases the growth is tuberous, and protrudes into the cavity of the bowel; in others, it forms a hard ring in the wall of the gut itself.

Pressure on the bowel from without by tumours, &c.—This is not a common cause of obstruction, for the bowel, being in most parts movable, is not readily compressed. Cancerous growths, from their tendency *to fix* and adhere to the tissues, more

often cause obstruction than innocent tumours, and as examples may be quoted cancer of the pancreas, spleen, kidney, and liver. In other cases, uterine, ovarian, or prostatic tumours compress the bowel, and in yet another class the obstruction is caused by the pressure of pus. Thus, I have seen a case in which an abscess which formed in Douglas's pouch as the sequel to rectal stricture and ulceration caused such pressure on the bowel as to induce death by obstruction, and other similar cases have been recorded. Occasionally, the glandular tumours which result from "tabes mesenterica" attain a sufficient size to compress the bowel, to which, in addition, they may contract adhesions.

Chronic peritonitis.—In tubercular disease of the peritoneum it is by no means uncommon for the coils of intestine to become matted to one another and to the enlarged glands which are often present. In consequence of this matting, a chronic form of obstruction may supervene. The condition is most common in young people. In another class of cases the peritoneal inflammation is dependent upon disseminated new growth. This is most frequently seen in connection with malignant ovarian disease, but in some cases the growth is primary in the serous membrane.

CHAPTER LX.

DISEASES OF THE RECTUM.

IMPERFORATE ANUS.

IMPERFORATE anus results from imperfect union between the rectum above and the posterior part of the cloaca common to the uro-genital aperture and the hind gut below.

The deformity exists in varying degrees. In some cases there is an anal depression, at the bottom of which a membrane forms a septum separating the anus from the rectum, or else the anus itself is occluded by a similar membrane, which extends backwards from the scrotum to the coccyx. In other cases, again, the anus and rectum are continuous, but the gut is much narrowed at the point of their junction, and occasionally the anal orifice is obstructed by a longitudinal fold of skin extending from the coccyx to the scrotum, and bisecting the anal aperture.

In more severe examples the anal aperture is separated from the rectum by fibrous tissue an inch or more in depth, whilst in some instances the rectum itself is completely undeveloped. Not infrequently the rectum opens into the genito-urinary tract—in the female into the posterior wall of the vagina, and in the male into the prostatic urethra; more rarely, the opening is into the bladder itself. Those cases in which there is no passage for fæces terminate fatally

unless subjected to surgical treatment, the infant dying from vomiting and exhaustion, or from rupture of the cæcum or colon caused by over-distension.

HÆMORRHOIDS.

Hæmorrhoids, or piles, constitute one of the most common of the diseases to which the rectum is liable. A hæmorrhoid is essentially a dilated or varicose vein, or more often a collection of such veins. According to their situation relative to the anal orifice, piles are called external or internal, but, although it is not uncommon to find internal piles existing alone, external piles are almost always associated with the internal variety.

External piles are covered by skin, and are generally multiple. When not inflamed, they give rise to but little trouble, and present themselves as swollen tabs of skin around the anal orifice. When inflamed, they form purple, shiny, tense, rounded masses, causing much pain and rectal tenesmus. If removed, they are found to consist of a looped varicose vein surrounded by fibrous tissue, the quantity and denseness of which depend upon the frequency with which the pile has been the seat of inflammation. Very commonly, the blood in the varicose vein clots when the latter becomes inflamed, and occasionally suppuration or sloughing terminates the existence of a hæmorrhoid.

Internal piles vary in structure, for, although all are composed of dilated vessels, the arrangement and character of the latter are not always identical. They may conveniently be divided into (*a*) capillary, (*b*) venous, (*c*) arterial.

Capillary piles are small, sessile swellings, with a papillated, mulberry-like surface which readily bleeds. This hæmorrhage, which is common in all cases of internal piles, is readily accounted for when we consider that the latter are covered by thin mucous membrane only, and not by skin, as are the external

nes, and that, in addition, they are exposed to the ressure and irritation of the hardened fæces of the ectum. Children are but seldom the subjects of piles, ut when such is the case it is the capillary pile which ; almost always found.

Venous piles are the most common of the internal æmorrhoids. They are usually multiple, and extend rom just inside the anal margin to a distance of one or wo inches up the rectum. They form irregular pedun-ulated swellings, purple in colour, soft in consistence, nd not so prone to bleed profusely as the capillary

FIG. 121.

The Inner Surface of a Rectum with some Large Internal Piles.

ariety. On section after removal, they are seen to e composed almost entirely of irregular varicose eins, surrounded by but little fibrous tissue, and a ew small arterioles.

Arterial piles are comparatively rare. They are enerally large, distinctly pedunculated, smooth and ippery on the surface, and readily bleed *per ultum* if scratched. They contain arteries of con-derable size, *as well as* varicose veins.

The **causes** of hæmorrhoids are numerous, but, in general terms, it may be said that they are induced by anything which impedes the return of blood from the rectum. It should be remembered that most of the rectal veins open into those of the portal system, and that, as the latter have no valves, the blood-pressure at the most dependent parts of the rectal vessels is necessarily considerable. In addition, the veins of the rectum run in a submucous tissue, which is more than usually lax and yielding—a condition which, although necessary on account of the constantly varying distension of the rectum, nevertheless gives but little support to the veins. Chronic constipation, which is one of the most fertile causes of piles, induces them in more ways than one. First, the fæcal masses compress the veins directly, and, secondly, the thickening of the muscular coat of the rectum, which often results from its distension, causes an increased difficulty in the flow of blood from the veins of the submucous tissue.

But the pressure on the rectal veins is often caused by diseased conditions of the rectum itself, and it should always be remembered that almost any disease of the rectum may be complicated by piles; this is a fact that has more than a pathological importance, for, if it is not recognized, the more serious mischief may be overlooked, and an operation be undertaken for the cure of piles when the latter are perhaps but a complication of a rectal stricture or new growth. In some cases pressure on the rectum may be caused by a pregnant uterus or a uterine fibroid, and in old men by an enlarged prostate. The impediment to the portal circulation caused by a congested liver, often the result of excessive indulgence in food and drink, and still more that caused by cirrhosis of the liver, tends to cause piles, whilst, in addition, the conditions which produce a more general congestion of the venous system, such as diseases of the heart and lungs, also exercise some influence.

Lastly, sedentary occupations and a feeble state of health, with loss or impairment of healthy muscular tone, such as is sometimes induced by residence in hot climates, must be mentioned as causes of hæmorrhoids, and it is probable that heredity is not without some influence, for in not a few cases hæmorrhoids occur in several members of the same family.

ISCHIO-RECTAL AND ANAL ABSCESS AND FISTULA IN ANO.

The abscesses which are common in the neighbourhood of the rectum and anus fall naturally into two divisions—those which are superficial and those which are deep. To the former the name of **anal** abscess is often applied, for they develop in the folds of skin which surround the anus. They never attain any great size, and readily burst externally; if they burst internally as well, the most usual place for the formation of the internal opening is the line of separation between the external and internal sphincters, *i.e.*, just within the anus itself.

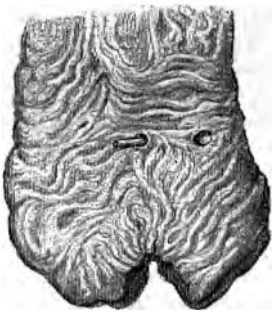
The deep or **ischio-rectal** abscesses are formed in the fossa of that name. They are situated beneath the deep fascia, and show but little tendency to come to the cutaneous surface, meeting with less resistance in their extension toward the bowel, into which they often burst above the upper margin of the internal sphincter, *i.e.*, about an inch and a quarter to an inch and a half up the rectum. Their formation is accompanied by much brawny swelling, with induration and pain.

Both anal and ischio-rectal abscesses may result from injury or exposure to wet and cold. Usually the injury is applied from without, but the presence of hard and sharp foreign substances in the rectum provides another source of traumatism, for by their passage through the mucous membrane they may allow of the escape of minute quantities of fæcal matter into the cellular tissue, and thus promote sup-

puration. The anal abscesses appear to owe their commencement in many cases to the irritation caused by want of cleanliness in this region.

A fistula in ano is the result of an unhealed abscess, and just as there are two kinds of abscesses, so are there two kinds of fistulæ. It must not be supposed that all abscesses in the neighbourhood of the rectum refuse to heal, for such is not the case, but, as a very large number of them lead to the formation of fistulæ, it is evident that some common cause or causes must be present in all cases. One of the most constant of these is the perpetual movement of the parts, for not

FIG. 122.



The Inner Surface of a Rectum with Two Small Tubercular Ulcers, into one of which a portion of glass rod has been passed.

only are the walls of the abscess drawn upon during defæcation or the passage of flatus, but the perineum is kept in motion by any violent respiratory act, and especially by coughing. Another fertile source of fistula is the passage of fæcal matter, and the irritation which is thereby set up whenever the abscess-cavity communicates with the bowel. The association of fistula with phthisis finds an explanation in the presence of tubercular ulceration of the rectum in this disease. The ulcer, which is generally ragged, with undermined edges, permits the escape of fæcal

atter, as already mentioned, and causes suppuration ound the gut. Lastly, as in the case of piles, it ust constantly be kept in mind that a fistula may be it a complication of some other rectal disease, such simple or cancerous stricture, syphilitic ulceration, sure, &c.

Three chief **varieties** of fistula are described—the mplete, the blind external, and the blind internal. **complete** fistula is one which opens both externally rough the skin and internally into the bowel; strictly eaking, this is the only form of true fistula, the hers being sinuses. A **blind external** fistula is ie which opens externally alone, but is "blind" wards the rectum, and, conversely, a **blind internal** fistula has an opening into the rectum alone, id none through the skin. The external opening is sually close to the anus, but in some cases is situated a distance of several inches, or, in rare instances, far away as the great trochanter. In healthy subcts this opening is small, and from it protrudes small mass of healthy florid granulations. In hthisical patients the aperture is often large and gged, the skin undermined and purple, and the base evoid of healthy granulations, and secreting a little atery pus.

The position of the internal opening depends iefly on the kind of abscess which has preceded the stula. If an anal one, then the aperture is just inside ie anus, between the external and internal sphincters; hilst if an ischio-rectal one, the opening is placed ove the internal sphincter, and is sometimes as much three or even four inches from the anus. The aracter of this orifice differs, as does that of the ternal one, according to the constitutional condition the patient. The fistulous track itself is lined at rst by the granulation tissue of the shrunken abscess-vity, but in cases of long standing the wall becomes ickened by fibrous tissue, and the canal is lined by dense cicatricial membrane, showing no tendency hatever to heal.

A fistula chiefly causes trouble by the discharge of matter and the incontinence of flatus and fæces, but, if it be neglected, further mischief will ensue. On account of the occasional blocking of the track, pus is liable to be retained at times, fresh abscesses form, and either burst again through the old opening or else point in fresh places. In this way other fistulous tracts are produced, which in many cases form branching channels leading from the original sinus. As this

FIG. 123.

A Rectum with Numerous Fistulæ and much Fibrous Thickening.

trouble is continuous so long as it is allowed to remain untreated, additional openings form in the bowel, the mucous membrane is destroyed by ulceration, and the submucous and muscular coats are infiltrated by fibrous tissue and other inflammatory products. In this manner the lower part of the bowel is converted into a tough fibrous tube, incapable alike of properly retaining fæces and of transmitting them, for the sphincters cease to act, not only because they are partly destroyed, but also because the mucous surface

no longer maintains its normal sensibility, and thus he presence of fæcal matter is not recognized by the atient, and does not excite the natural reflex contraction of the muscles. On account of the contraction f the newly formed fibrous tissue, much narrowing nay ensue, and thus lead to the development of a tricture. Some few cases terminate fatally from exaustion, caused by profuse suppuration; others, from cute peritonitis consequent on the perforation of an lcer through some part of the rectum covered by eritoneum.

ANAL FISSURE.

In fissure of the anus there is, as the name implies, crack or fissure at the anal orifice. In very many ases no other cause is apparent beyond chronic contipation, and it is probable that the disease generally esults from over-distension by hardened masses of æces. In some instances the fissure is slight and eadily heals even without treatment, but usually extends, and shows little tendency to spontaneous ure. The common situation of a fissure is the posrior margin of the anus; it usually reaches about alf an inch or more up the bowel, and an examinaon may show that it is complicated by the presence f either piles or a polypus. It is of some importance recognize such a complication, for, if the growth be ot removed, the treatment of the fissure is liable to rove abortive. Fissures cause much pain, which is pecially severe after defæcation, and it is supposed at both this symptom and their slowness to heal re alike accounted for by the exposure of nervous vigs in the floor of the fissure.

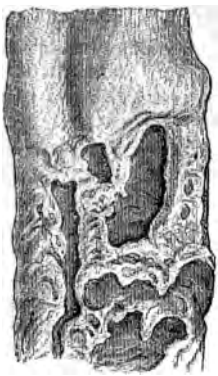
ULCERS OF THE RECTUM.

Simple ulceration of the rectum is usually of traatic origin, and is the result of the presence of rdened masses of fæces or of foreign bodies in the ctum. The ulcer is usually single, and may be

situated at any part of the circumference of the bowel. It is seldom larger than a shilling, and is of no regular shape; its base and edges are neither indurated nor unduly prominent. As already mentioned, ulceration of the rectum may lead to the formation of a fistula, and the fistula, in its turn, may be followed by an ulceration which extends up the rectum, and sometimes involves the mucous membrane in the greater part of its length.

Syphilitic ulceration is more common in women than in men, and is usually a tertiary affection. It may, however, be said at once that cases are attributed to syphilis in which there is no evidence of this disease, and it is probable that many instances of so-called syphilitic disease are really examples of simple ulceration extending up the gut, as already described in the chapter on Fistula.

FIG. 124.



The Inner Surface of a Rectum with Syphilitic Ulceration, which has in part destroyed the mucous membrane.

In typical syphilitic disease the mucous membrane of the rectum is thickly studded with small oval or rounded ulcers, the size of a pea or a lentil. These have at first but little induration of their bases, and the edges are sharply cut, and not overhanging like those of a tubercular ulcer. By their increase in size, these ulcers coalesce, and thus the mucous membrane is destroyed over an area of irregular shape. The infiltration of the rest of the rectal wall by the products of inflammation results after a time in the production of fibrous tissue, and is followed by induration and contraction of the calibre of the gut. The ulceration tends to spread up the bowel, and in this way there

is first a destruction of the mucous lining and then a formation of fibrous tissue, which may in time implicate the rectum in its whole length. The discharge from the ulcerated surface is often very profuse, and in some cases the ulcers penetrate deeply into the surrounding parts. In consequence of this penetration, fistulæ are liable to form, and in some cases extend into neighbouring organs, such as the vagina or the bladder. If an ulcer penetrates the rectal wall where the latter is covered by peritoneum, acute suppurative peritonitis quickly ends the patient's life. In other cases death results from exhaustion. In connection with this subject, it may be mentioned that in secondary syphilis the anus is very frequently the seat of condylomata or mucous tubercles, such as have been more fully described in the chapter on Syphilis.

Tubercular ulceration of the intestine, and the part it plays in the production of fistulæ, have already been described, and it now only remains to mention briefly the other and rarer causes of ulceration. These are chiefly **dysentery** and **catarrh**, for the ulceration which is the almost constant accompaniment of new growths is better dealt with in connection with tumours of the rectum. Dysenteric ulceration is often very chronic, and may persist for years. The scars left by it are frequently pigmented. In rare cases it causes penetration of the rectal walls, with the formation of fistulæ. It is peculiarly liable to be followed by abscess of the liver.

STRICTURE OF THE RECTUM.

Rectal stricture results either from inflammation and ulceration or from the presence of new growths. Any of the varieties of ulceration described above may result in the formation of a simple stricture, which, in addition, may ensue upon pelvic cellulitis or other forms of inflammation connected with the female

genital organs. In some cases stricture close to the anal orifice is dependent upon imperfect development of the communication between the bowel and the skin surface. Occasionally, stricture results from the too free removal of skin in operations upon hæmorrhoids.

Stricture occurs in all parts of the rectum, and may be either annular or tubular. In the former, there is a narrow ring-like contraction of the gut; in the latter, the rectal walls are infiltrated in a considerable part of their length. In many cases in which there has been extensive ulceration, and the stricture is of long standing, the lowest portion of the gut is found, when examined by the finger, to be extremely rough and irregular, the walls being exceedingly hard and resistant, and the bowel fixed to the surrounding parts. The rectum above the stricture becomes greatly hypertrophied and dilated on account of the obstruction to the passage of fæces, and, on account of the retention of the latter, is liable to become inflamed and ulcerated. The ulceration, in its turn, is followed by contraction of the scar tissue, and thus the stricture extends.

The ulcerated and dilated condition of the gut above the obstruction affords a ready explanation of some of the most typical symptoms of stricture. It is common in these cases to have a history of alternating attacks of constipation and diarrhœa. The constipation is the result of the accumulation of fæces above the stricture, and it is the presence of the fæcal masses which causes irritation and catarrh of the bowel, resulting in discharge of the accumulated fæces mixed with, and liquefied by, the secretion of the intestine. The ulcerated surface also supplies a discharge of pus and mucus, which collects above the sphincters, and causes frequent desire to defæcate, the patient passing a mixture of pus and blood. When the stricture is near the anus, the motions are moulded by it rather than by the anal orifice, and become narrow and pipe-like; but if the obstruction be in the upper part of the

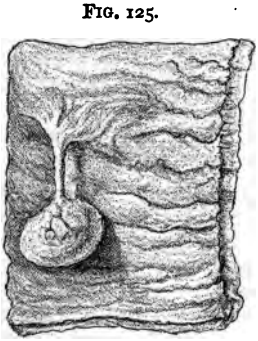
rectum, the fæces collect again below the stricture, are welded by the muscular rectal walls, and finally shaped by the anus, so that any narrowing which has been produced in the passage through the stricture is lost in the rectum below it.

Stricture of the rectum may end fatally in more ways than one. In some cases the discharge from the ulcerated surface causes death by exhaustion or amyloid disease; in others, additional trouble results from the implication of the bladder and the formation of a fistulous communication; sometimes peritonitis is caused by the penetration of an ulcer high up the bowel; and, lastly, the opposition to the passage of fæces may culminate in complete intestinal obstruction.

TUMOURS OF THE RECTUM AND ANUS.

Tumours of the rectum, like those of other parts, are either innocent or malignant; the former will be first described.

FIG. 125.



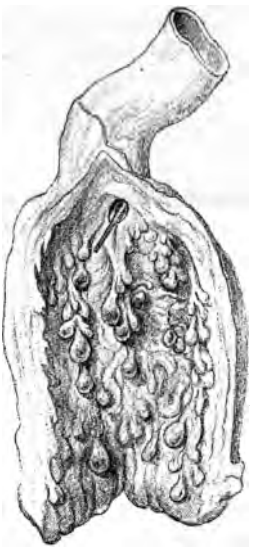
Portion of a Rectum with a Pedunculated Glandular Polypus.

Papillomata are sometimes, though not frequently, met with around the anal orifice. They present the same appearances as similar growths elsewhere, being

roughened on the surface, not indurated nor infiltrating the surrounding tissues, and often discharging a watery, blood-stained fluid. They are usually small, but occasionally attain considerable proportions. They occur chiefly in adults.

Polypi are found at all ages, but are relatively common in children. They are either (*a*) glandular or (*b*) fibrous. The **glandular** or adenomatous polypi are usually about the size of a small hazel-nut, are attached by a stalk or pedicle which is often an inch or two in length, have a papillated surface, and are prone to bleed. In rare instances they are multiple, and may be numbered by hundreds, extending up the rectum as far as the finger can reach, and bleeding profusely. On microscopical examination, these glandular growths are found to consist of numerous Lieberkuhn's follicles closely set in a matrix of loose fibrous tissue.

FIG. 126.



A Rectum with Multiple Glandular Polypi.

The **fibrous** polypi are not so common as the adenomatous ones. Their surface is smoother, their pedicles shorter, and their tendency to bleed not so marked as in the case of the glandular polypi. Sometimes they attain a very considerable size, and there is a specimen in the museum of St. Bartholomew's Hospital which was removed by my friend Mr. Everley Taylor from a girl of about twenty, and weighed no less than a pound. Such cases are, however, extremely

rare. On microscopical examination, these polypi are seen to be composed of loose connective tissue; sometimes they are very soft, and contain much serous fluid in the connective-tissue spaces.

Dermoid tumours of congenital origin, and polypoid in shape, have been occasionally met with in the rectum; they are sometimes covered by long silky hairs.

Nævi are very rare, but are liable to be dangerous to the life of the patient by reason of the copious hæmorrhage which they occasionally cause. Like similar growths in other parts, they are met with in children.

Malignant tumours of the rectum are practically always carcinomata, for the sarcomata are so rare that they do not require separate mention. But, although all the malignant growths are of epithelial origin, they are not all alike either in their physical properties or microscopical structure, and may conveniently be divided into two classes—(*a*) the adenoid or glandular cancers and (*b*) the scirrhous cancers.

The **adenoid carcinomata** have been shown by Mr. Cripps to form the greater number of the malignant tumours of the rectum. They may grow in any part of its length, but are of more frequent occurrence in the lower than in the upper part of this portion of the bowel. They grow from the mucous membrane, and show a great tendency to extend into the lumen of the gut. At first they are covered by the mucous membrane, and form soft, partially pedunculated, smooth masses, movable on the deeper part of the rectal walls. As they increase in size, their surface becomes ulcerated and discharges a mixture of blood and mucus, their deeper portions grow into, and gradually implicate, the whole rectal wall, and, chiefly as the result of irritation, they become more firm and indurated. Their growth is not rapid, and may extend over periods of even four or five years or more. Sometimes they implicate neighbouring organs, and

cause fistulous openings into the bladder or vagina, or on to the neighbouring cutaneous surface. In some instances they neither infect the lymphatic glands nor cause secondary growths, but at other times the reverse is the case, and the liver more than the other viscera is liable to metastatic deposits.

On microscopical examination, adenoid cancers are found to be composed of a loose fibrillar stroma, in which are embedded numerous tubular glands lined with columnar epithelium, as well as masses of epithelial cells lying loose in alveoli, and not forming any definite

FIG. 127.

The Inner Surface of a Rectum with an ulcerated mass of Adenoid Carcinoma.

glandular structure. In these tumours, indeed, there may often be seen all gradations of structure between a definite adenoma and a typical carcinoma, and, as a result, there are many irregularly formed and imperfectly developed gland-tubules. It is not always easy to say at first sight whether a given growth is a simple adenoma or an adenoid cancer, but the point may be settled by noticing whether or not the *growth* implicates the submucous and muscular coats. *If it* does so, then the tumour must be looked upon as

malignant; whereas if it is only a surface-growth, not infiltrating the rectal wall, it must be considered a simple glandular polyp.

Scirrhous cancers are more common in the lower than in the upper part of the rectum. Unlike the adenoid cancers, they do not tend to the formation of polypoid-like masses protruding into the cavity of the

FIG. 128.

Section of an Adenoid Carcinoma of the Rectum showing the irregular cavities lined by columnar epithelium. (Zeiss, A.)

bowel, but rather simply infiltrate its walls. Both the glandular cancers and the scirrhous growths cause a narrowing of the calibre of the gut, and produce the so-called malignant stricture of the rectum, but the scirrhous growth is much more dense and fibrous, and by its contraction renders the rectal walls infinitely more rigid and undilatable than does the

adenoid carcinoma. The mucous membrane covering the tumour ulcerates early, and exposes a readily bleeding surface, which discharges a foul-smelling and watery secretion. The growth may extend into the neighbouring viscera and tissues, and sometimes attains so great a size as to fill the lower aperture of the pelvis and compress all the pelvic viscera. The bowel above the growth becomes dilated and ulcerated, as in the case of other strictures, and in some instances the disease is complicated by the formation of fistulæ or of piles. Glandular enlargement and metastatic growths are of common occurrence, and death ensues either from visceral disease, or else, more commonly, from exhaustion induced by pain and profuse discharge or from intestinal obstruction. On microscopical examination, these tumours show the dense fibrous stroma arranged so as to form alveoli of irregular shape and size, such as are common to all scirrhous growths. The epithelial cells contained in the alveoli are in some cases spherical but more often columnar in shape.

PROLAPSUS ANI ET RECTI.

The former of these terms is applied to an abnormal protrusion or eversion of the mucous membrane of the rectum through the anal orifice; the latter, to an eversion of the whole thickness of the rectal wall. The mucous membrane of the rectum is normally so loose that it protrudes slightly during defæcation, and anything which causes excessive straining will result in excessive protrusion or prolapse. The commonest cause of prolapse of the anus or rectum is intestinal irritation caused by the ingestion of unsuitable food, and we thus find the disease most often in unhealthy, ill-fed, flabby, and rickety children. Any disease of the rectum may be complicated by prolapse, but those which most often induce the trouble are rectal polypus, piles, and thread-worms. Prolapse is also liable to result from any disease of the urinary organs which

induces straining, and is common in children suffering from phimosis or calculus.

The extent of the prolapse varies greatly; in some cases only a small fold of mucous membrane protrudes, whilst in others several inches of the lower part of the rectum projects as a tube from the anus; the prolapse tends to increase so long as its cause remains. At first the mucous membrane is everted only during straining, but as time goes on the sphincters become lax and atonic, the attachment of the mucous membrane to the submucous tissue less and less firm, and, finally, the bowel is more often prolapsed than not. The result of the constant exposure is an inflammation of the mucous lining, accompanied by a catarrhal discharge, and in cases of long standing this may be succeeded by ulceration or even sloughing of the prolapsed parts, the latter being usually the result of a strangulation of the protrusion by the anal orifice.

PRURITUS ANI.

This is a term applied to a sensation of itching and irritation of the anus and surrounding skin. It sometimes complicates piles, or may result from the presence of rectal worms, but is most often caused by over-feeding and its accompanying constipation and congested liver; it is also common in gouty subjects. As a result of the irritation and consequent scratching, the skin may become eczematous.

CHAPTER LXI.

PERITONITIS.

INFLAMMATION of the peritoneum may be either ac or chronic, diffuse or localized. The acute infl mations are usually also diffuse, but the chronic not necessarily localized, although this is freque the case.

Acute diffuse peritonitis is a septic, spreac inflammation of the peritoneum. It may result f such causes as penetrating wounds of the abdom wall; extension of inflammation from neighbou parts—*e.g.*, from the cellular tissue in cases of uri extravasation; rupture of the stomach or bowe their perforation by ulcers, tumours, or foreign bo and the escape of the intestinal contents—so-ca "perforative peritonitis;" rupture of abscesses into peritoneum, especially of perityphlitic abscesses; grene of the gut following strangulation or any of varieties of intestinal obstruction; and septic co tions of the system, such as septicæmia and pyæm

The commencement of peritonitis is marked b great distension of the vessels, and a consequent dening of the inflamed part. This is usually noticeable, and at once attracts attention when abdomen is opened at a post-mortem inspection. the inflammation progresses the redness becomes noticeable, the surface appears dull, and on cl examination this alteration in colour is found t the result of exudation, which covers the infla

·ts with a thin layer of fibrin, and causes the surface the intestine to assume a finely granular or groundss appearance. Very soon, as the exudation inases, the serous surface becomes flocculent, and ·eds of fibrin in the form of a fine network may be n crossing each other in an irregular fashion. The ·in also causes adhesion of the folds of intestine, so ıt the latter are found to be stuck together and ·tially fixed to the parietal peritoneum. The inteses themselves are greatly distended, and contain ge quantities of gas—a condition which results from ·alysis of their muscular coats.

[n the later stages of septic peritonitis, the serous ·ity is more or less filled by fluid, which at first is ous and blood-stained, but soon assumes a flocculent ɔearance, with shreds of fibrin floating in it, and ılly becomes purulent. The fluid collects in the st dependent parts, and especially in the pelvis, ; it is also prone to become localized by adhesions med between the intestinal folds, and may thus m collections shut off in parts from the general ·itoneal cavity. The intestinal walls are also swollen exuded fluid, and softened so that they are easily erated; in some cases the distended capillaries e way, and cause small sub-serous petechiæ or hymoses.

Microscopical examination shows that in the early ges of the affection there is an exudation of serum l leucocytes, and a separation of the endothelial ls which line the serous membrane. As the inflamtion progresses both red blood-cells and the fibrinming elements of the blood exude, and the coagulated ·in is deposited on the inflamed surface or floats in ·es in the exudation. More and more leucocytes ke their appearance, and soon the fluid is so laden ;h them as to become sero-purulent or purulent. netimes free gas, the result of decomposition, is nd in the abdominal cavity. In acute diffuse ·itonitis *the conditions* described are found in all

parts of the serous membrane, but where, as is usually the case, the inflammation has extended from some definite place, there all the signs will be found more accentuated and advanced than elsewhere.

Peritonitis, in the absence of treatment, is almost invariably fatal. It is accompanied by severe collapse, with persistent sickness and constipation, and the general symptoms of septic poisoning. In otherwise healthy adults there is usually severe pain, and, at first, pyrexia; but in old and feeble patients there is often but little pain, and the temperature is frequently sub-normal.

Sub-acute and chronic, localized peritonitis commonly results from an extension of some inflammatory process in or around one of the viscera. Thus, it is frequently caused by inflammation of the cellular tissue around the cæcum, of the uterus or ovaries, of the bladder in cases of chronic cystitis, &c. It is found in the neighbourhood of chronic ulcers of the stomach and duodenum, and around the liver in cirrhosis. In another class of cases it results from the irritation of new growths—*e.g.*, cancer of the liver, pancreas, stomach, &c.—or may be set up by contusion of any part of the abdominal wall.

The appearances met with in this form of peritonitis are very similar to those seen in the earlier stages of the acute form of the disease already described. The redness, however, is less marked, and the exudation of fluid is but slight. In these cases, moreover, there is a tendency to the development of fibrous adhesions, and, in place of the slight stickiness seen in the acute inflammation, there is a formation of fibrous tissue, which causes fixation of various viscera to one another or to the abdominal parietes. These fibrous bands are in some cases gradually elongated by the constant dragging of the attached tissues, and may thus at some future time be a cause of entanglement and strangulation of intestine in the manner already described in the chapter on Intestinal Obstruction.

In their mode of formation these bands do not differ from the fibrous tissue which forms the scar in the case of a wound; they are developed from the exuded leucocytes, and the blood-vessels which at first permeate them subsequently shrivel and disappear.

Chronic diffuse peritonitis may be the sequel of habitual engorgement of the serous membrane resulting from diseased conditions of the heart, lungs, or liver; it is also met with in cases of chronic interstitial nephritis. In cases of disseminated new growth—such, *e.g.*, as results sometimes from malignant ovarian disease—chronic peritonitis, with effusion of plastic lymph and the formation of adhesions, is of common occurrence. The changes met with in the localized form of the disease are seen in the diffuse variety spread over a larger area, but thickening of the serous membrane is more common in the diffuse than in the localized affection. Another and very important cause of chronic diffuse peritonitis is tubercle. In examples of this form of inflammation, the serous membrane becomes thickly studded with grey tubercles, which in some cases are present in such numbers as almost to completely cover the whole secreting surface. There is much matting of the intestinal coils, and exudation of a considerable amount of fluid; the mesenteric glands are commonly much enlarged, and often form masses of large size, to which the intestines become adherent. Tubercular peritonitis is usually part of a general tuberculosis.

CHAPTER LXII.

DEFORMITIES OF THE FACE AND SKULL.

HARE-LIP AND CLEFT PALATE.

THE causes of the deformities known as hare-lip and cleft palate are best explained by reference to the development of the face. The nose and mouth at first form one large cavity, which is subsequently partitioned off by growths from its roof and lateral boundaries. From the roof the "naso-frontal process" descends, and from the tissues forming it there are developed in the middle line the nose with its septum, the central portion of the lip, and the pre-maxillary bone, or that portion of the upper jaw which carries the incisor teeth. The naso-buccal cavity is thus separated into two lateral portions, which are subsequently represented on each side by the nostril and the antrum.

From the sides of the common cavity two other processes simultaneously develop, and grow inwards towards the middle line. These are named the "maxillary processes," or the "superior maxillary plates," and from them the cheeks, the sides of the lips, and the whole of the upper jaw, with the exception of the inter-maxillary bone, are formed, the cavity of the nose being now shut off from that of the mouth by the hard palate.

Both hare-lip and cleft palate result from a failure in the normal union between the naso-frontal and the

maxillary processes. If that part of the latter which forms the lateral portion of the lip fails to join on one side with the central portion of the lip, a "single hare-lip" results. If the failure occurs on both sides, the hare-lip is said to be double.

If the two maxillary plates do not fuse in the middle line of the palate posteriorly, the uvula is bifid or the soft palate cleft. If the failure to join is more complete, the hard palate is fissured, the fissure being in the middle line posteriorly, but running to one side or another of the inter-maxillary bone anteriorly, and thus is seen in front as a cleft between the lateral incisor and the canine tooth. In hare-lip the deformity may consist of nothing more than a slight notch on the mucous edge to one side of the middle line. More commonly, however, there is a greater failure, and the cleft passes through the whole depth of the lip and perhaps into the nostril. When the deformity is double, the central portion of the lip may be attached to the end of the nose.

In the slighter varieties of cleft palate, as already mentioned, the soft palate alone may be implicated, but in the more common form, where the cleft extends to the bony structures, the imperfection results in a communication between the nose and mouth, with consequent difficulty in swallowing, and sucking, combined with a nasal intonation of the voice. The reason why the cleft in the hard palate is in the middle line behind, but to one side in front, is that the posterior parts of the palatine processes are formed from the maxillary plates alone, whilst the arch is completed in front by the inter-maxillary bone. The fissure behind is thus a cleft between the two maxillary plates; in front, between the maxillary plate and the naso-frontal process, or that part of the latter called the inter-maxillary bone.

The nasal septum is usually attached below to the palatine process on the side opposite to that on which the deformity occurs. In some instances, however,

the cleft is double in front, the inter-maxillary bone not being united to the maxillæ on either side, in which case the nasal septum also is unattached except to the inter-maxillary bone.

It only remains to be added that in severe examples of cleft palate there is almost always hare-lip, and that, *vice versâ*, bad cases of the latter are usually complicated by cleft palate. The incisor teeth in cases of cleft palate are commonly undeveloped or imperfectly formed.

MENINGOCELE AND ENCEPHALOCELE.

Cerebral meningocele and encephalocele are protrusions of the cerebral membranes or of the brain itself through abnormal apertures in the skull. The most common site for such a protrusion is the occipital region, just behind the foramen magnum. In other cases the tumour appears at the anterior fontanelle; at the root of the nose, between the nasal and frontal bones; at the base of the skull, passing into the nares or pharynx; and, lastly, at the external angles of the orbit.

The membranes that are protruded are the dura mater and arachnoid, the cyst being distended by cerebro-spinal fluid. When the cyst contains brain matter, the latter is generally thrust out by distension of the ventricles with fluid. Meningocele is commonly associated with hydrocephalus.

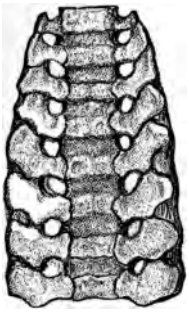
CHAPTER LXIII.

SPINA BIFIDA.

A SPINA BIFIDA is a congenital deformity of the spinal canal, with protrusion of a portion of its contents in the form of a cystic tumour.*

The bony deformity which is present in these cases consists of a deficiency in the laminæ and spines of one or more vertebræ, the spinal canal being thus left unclosed posteriorly. The laminæ may be merely stunted, but in bad cases are completely everted so as to stand out at right angles from the axis of the spinal column. As rare variations may be mentioned —(*a*) bony outgrowths from the posterior surface of the bodies of the vertebræ into the spinal canal, which may protrude through the centre of the cord itself; (*b*) cleavage of the body of a vertebra, and protrusion of the membranes anteriorly.

FIG. 129.



Portion of a Spine from a case of Cervical Spina Bifida, showing the absence of the laminæ and spinous processes.

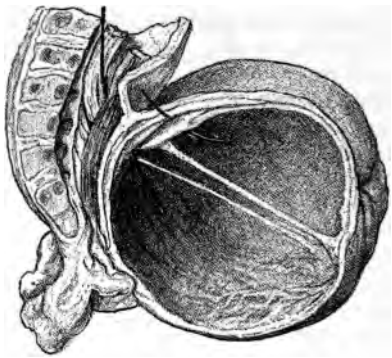
The common **position** of a spina bifida is the lumbo-sacral region,

* For a full account of the morbid appearances found in different cases of spina bifida, see a report of a committee of the Clinical Society in vol. xviii. of their "Reports," from which this chapter has been in great part compiled.

but it may occur in any part of the spine. In most cases some five or six of the vertebræ are deformed, but in exceptional instances the whole of the laminæ are deficient from the atlas downwards. Between these conditions all grades may be seen.

The **structure of the sac** and the composition of its contents differ in different specimens, and allow of a subdivision into three classes—first, meningocele; second, meningo-myelocele; third, syringo-myelocele.

FIG. 130.



Spina Bifida.—A Meningo-myelocele. One bristle has been passed from the sub-arachnoid space into the sac, and another has been placed beneath the spinal cord just before the latter becomes spread out on the upper part of the sac-wall. The filum terminale is stretched across the cavity of the sac, and is adherent to the most posterior part of the latter.

In **Meningocele** the sac is composed of dura mater and arachnoid, but contains neither the spinal cord nor any nerves, and is distended by the sub-arachnoid or cerebro-spinal fluid. It is doubtful whether one layer of the arachnoid alone is ever protruded, though *this* condition has been described. In such cases the *sac* would contain the arachnoid fluid.

In **Meningo-myelocele,** which is the most common form of spina bifida, the sac is formed by the dura mater and arachnoid, and contains cerebro-spinal fluid, with the spinal cord and its nerves. In lumbo-sacral spina bifida the **spinal cord** usually passes directly backwards, and the filum terminale is found adherent to the lower and posterior portion of the sac. In some specimens the cord becomes adherent to the upper part of the sac as soon as it enters it, and is spread out over, and incorporated with, the sac-wall itself. In cases of spina bifida in the dorsal or cervical regions the spinal cord passes through the sac, re-enters the spinal canal, and is found in its natural position in the lumbar region. In its passage through the sac it may be free, but is in some instances adherent to the posterior surface of the sac-wall, as in the lumbo-sacral class. In all cases of spina bifida the central canal of the cord is liable to be distended.

The **nerves** which arise from that part of the spinal cord which is included in the spina bifida are necessarily themselves within the cavity of the sac, the anterior and posterior roots being often easily differentiated and found separated from one another by a continuation of the ligamentum denticulatum. That part of the cord which is fused with the posterior portion of the sac-wall also gives off nerve-roots, and thus the latter appear to *originate* from the sac-wall itself, though they are often erroneously described as being *distributed* to it. (See Fig. 130.)

The **form** and **size** of the **sac** vary greatly. At birth it is usually small, not larger than a Tangerine orange, whilst in some cases the position of the spina bifida is marked by a depression instead of a swelling. During the first few days of life the sac increases with some rapidity, and has been seen to measure in adults as much as 27 inches round its base. Its shape is circular, and, although generally sessile, there is a marked constriction where it is connected with the *trunk; in long-standing* cases a pedicle is gradu-

nlly formed. The most posterior portion of the sac, or the summit, frequently presents a median groove, furrow, or depression, to which the name of "the umbilicus" has been given. It is generally the result of the attachment of the spinal cord in this situation, and is caused by the unequal distension of the sac by its contained fluid. (See Fig. 131.) The central canal of the spinal cord has been seen to open at the bottom of the umbilicus. Occasionally, the sac is divided into

FIG. 131.

Spina Bifida, showing the umbilicus, or central depression, where the spinal cord is adherent to the sac-wall.

partitions by septa, and these also may produce depressions or grooves.

The **coverings of the sac** are rarely normal skin and subcutaneous tissue. In most cases the base alone is covered by skin, which gradually thins away towards the fundus, so that the summit of the latter is either covered by a thin layer of epidermis or by a glistening membrane composed of the spinal membranes or of the thinned and adherent cord.

Syringo-myelocele is a rare form of spina bifida in which the central canal of the cord is immensely distended and forms the sac-cavity, the sac-wall being lined by the expanded spinal cord itself. At first

sight such a spina bifida might easily be mistaken for a simple meningocele, for no nerves traverse the sac-cavity. Close examination, however, shows that the nerves are contained in the substance of the sac-wall, being given off from the distended cord.

The coverings of a syringo-myelocele are of the same nature as those of a meningo-myelocele.

The congenital deficiency which results in the formation of any spina bifida consists in an imperfect development of the mesoblast on each side of the vertebral furrow from which the spinal meninges and the vertebral laminæ are normally produced. The mesoblast being deficient, these structures remain undeveloped in varying degrees.

The complications of spina bifida which are common are hydrocephalus, talipes, and paralysis of the rectum and bladder.

The termination of the majority of cases of spina bifida is death. This commonly results from the sac giving way, an event which is followed by myelitis or convulsions. Other children die in a marasmic condition, without any very definite lesions being present. In a small proportion of the meningo-myeloceles, and in a considerable number of the simple meningoceles, the sac gradually shrinks and a natural cure is effected.

CHAPTER LXIV.

TALIPES—CLUB-FOOT.

TALIPES, or club-foot, may be either congenital or acquired, may affect one or both feet, and is equally common in male and female children.

CAUSES.

The **congenital** form is attributed by different authors to three different causes—(1) spasmodic contraction or paralysis of muscles, resulting from nerve-irritation or loss of function; (2) malformation of the tarsal bones; (3) mechanical pressure by the uterus, or by malposition of the fœtus.

The theory that the deformity is due to some affection of the nervous centres is supported, first, by the undoubted fact that after birth talipes certainly results in many cases from disease of the spinal cord, and, second, by the very frequent association of malformations of the cord and brain such as are seen in spina bifida and anencephalus.

In the absence of any demonstrations of primary disease of the spinal cord in the fœtus, the proof that myelitis produces congenital talipes must be declared wanting, although there is much to be said in its favour from a theoretical point of view. The frequent association with spina bifida and anencephalus is, however, a fact which renders it highly probable that their co-existence is more than a coincidence, and that, in these cases at any rate, the deformity of the

foot is the direct result of the lesion of the cord which is commonly present.

The second theory, which explains the deformity by imperfect development of the tarsal bones, is probably erroneous, the changes found in the latter being the result, and not the cause, of the talipes.

The third theory, that the club-foot is the result of mechanical pressure by the uterus or by adventitious bands, or of malposition of the fœtus, finds its greatest support in a paper by Messrs. Parker and Shattock,* and may be summed up in their own words:—"Our argument is that the feet of the fœtus occupy various positions during the course of intra-uterine life, and that this occurs in order that the joint-surfaces, the muscles, and especially the ligaments be developed so as to allow of that variety of positions and movements which are afterwards to be natural to the foot; and we hold that when anything (mechanically) prevents the feet from assuming these positions at the proper time, or maintains them in any given position beyond the limit of time during which they should occupy such position, a talipes results. The variety of talipes will depend on the date of its production; its severity will be in direct ratio to the mechanical violence at work. If the inversion of the foot, which is normal during the earlier months of fœtal life, be maintained beyond the normal period of time, the muscles and ligaments will as a consequence be adaptively short on one aspect of the limb, and too long on the other—a normal position of inversion will finally become a deformity. Talipes calcaneus is, we believe, produced in a similar manner; it occurs, however, later during intra-uterine life, when a flexed position of the foot is normal. Being thus less fundamental in character, as a deformity it is also less severe than varus."

* "Transactions of the Pathological Society," vol. xxxv. p. 423.

In support of this explanation the authors adduce various examples of fœtal malposition and pressure which seem quite sufficient to prove that the theories they advocate are supported by facts, and to establish such mechanical conditions as one of the causes of congenital club-foot, and probably the one which is most frequently operative.

Acquired talipes commonly results from disease of the spinal cord. This in some cases is irritative in its nature and produces spasm of certain muscles, which, at first by their vital contraction, and afterwards by their tendency to become permanently shortened, cause an active displacement of the foot; *e.g.*, spasm of the calf muscles will result in a drawing up of the heel, or "talipes equinus."

In another class of cases the lesion of the cord is of a destructive nature, the large nerve-cells in the anterior cornua being destroyed. This lesion, which is known as "anterior polio-myelitis," results in the condition called "infantile paralysis." The motor cells, which are the centres of nutrition for the motor nerves and the muscles they supply, being destroyed, the nervous and muscular fibres degenerate and atrophy, and deformities are produced both by shrinking of the paralysed muscles as well as in other cases by their stretching. Thus, if all the muscles of the leg are paralysed, the foot usually hangs in a helpless condition, with the toes pointed and somewhat inverted, and in this position, that of "talipes equino-varus," it may be permanently fixed in the course of months by the atrophy and shrinking of the calf-muscles. In other cases, where the calf-muscles are alone or chiefly affected, the extensors will support the foot, and the pressure on the sole in walking will tend to stretch the wasted soleus and gastrocnemius until the heel is permanently depressed and "talipes calcaneus" is produced. In some cases of polio-myelitis the paralysis passes off, but unless this improvement occurs within the first month or two

after the attack there is little probability of recovery; the muscles then rapidly waste, the skin becomes blue and cold, and, unless precautionary measures are taken, deformities such as have been described will be developed. In advanced cases the muscles consist of little else than fat.

In a few cases talipes is caused by contraction of scars about the ankle-joint, and, as will be explained in the sections on flat-foot and valgus, it is also the result of muscular weakness and yielding of ligaments. Again, when one limb is shorter than the other—*e.g.*, as the result of hip disease—the constant walking on the toes may produce permanent talipes equinus.

TALIPES EQUINO-VARUS.

Talipes equino-varus is the commonest form of club-foot, and is in most cases congenital. In this variety the toes are pointed and the sole cannot be brought up to a right angle with the leg; the foot is also turned inwards so that the scaphoid bone is approximated to the internal malleolus. In severe cases the patient walks on the outer side and dorsum of the foot, and, as a consequence, the skin in this situation becomes much thickened, and a subcutaneous bursa usually forms. If such a deformed foot be examined, the tendons of the tibialis anticus and the tibialis posticus as well as the tendo-Achillis are found to be abnormally short; the internal lateral ligament of the ankle and the ligaments uniting the tarsal bones on the inner side are in a similar condition, whilst those on the outer side may be stretched. The astragalus is in most cases normally placed as regards the tibia and fibula, except that, in proportion to the amount of the equinus, it is depressed anteriorly so that the greater part of the surface which articulates with the tibia is exposed. The twisting inwards of the foot, or the "varus," is found to take place at the mid-tarsal and sub-astragaloid joints, and not at the *ankle, the scaphoid* being displaced almost completely

in severe cases to the inner side of the astragalus, so that the articular surface of the head of the latter bone is unopposed in front, and a new articular facet is formed on the inner side of the head to articulate with the navicular bone in its altered position. In addition to this, Messrs. Parker and Shattock have noticed an extension backwards of the upper articular or trochlear surface and an undue obliquity of the neck of the astragalus.

In old cases of equino-varus, moreover, the bones on the inner side of the foot are compressed and undeveloped, the skin on the outer side forms a hard,

FIG. 132.

Dissection of a Foot with Talipes Equino-varus.

horny excrescence, and the muscles of the calf are small and feeble from the little use to which they are put, the movements of the ankle-joint being in these patients almost in abeyance.

TALIPES EQUINUS.

Talipes equinus consists in an inability to bring the sole of the foot up to a right angle with the leg. The

toes are consequently pointed, and the heel is raised from the ground in walking. In exaggerated cases the plantar flexion of the foot is carried to such an extent that the patient walks on the dorsal surface of the toes.

Pure equinus is rare. It is seldom congenital, and commonly results from infantile paralysis or from spastic contraction of the calf-muscles. The chief anatomical lesion is shortening of the tendo-Achillis or of the muscles inserted into it.

TALIPES VARUS.

Talipes varus uncomplicated with equinus is a rare form of club-foot, and is almost always congenital. It is characterized by inversion of the foot and shortening of the tibialis anticus and posticus. Most of what has been written already on the anatomical changes in talipes equino-varus applies also to varus.

TALIPES CAVUS.

Talipes cavus is an exaggeration of the normal plantar arch, the sole of the foot being deeply hollowed and the dorsum correspondingly convex and arched. This form of club-foot is invariably acquired, and is almost always combined with equinus or equino-varus. The toes also, in this variety of deformity, present conditions which are seldom seen apart from cavus, the first phalanges being hyper-extended or even dislocated backwards on their metatarsal bones, whilst the second and third phalanges are doubled down towards the sole.

This "hollow claw-foot" results either from a paralysis of the interossei, or in consequence of an antecedent equinus. The interossei normally flex the first phalanges and extend the second and third; consequently, when they are paralysed, there being no muscle to depress the first phalanges during the movements of the foot, the common extensor displaces

ally formed. The most posterior portion of the sac, or the summit, frequently presents a median groove, furrow, or depression, to which the name of "the umbilicus" has been given. It is generally the result of the attachment of the spinal cord in this situation, and is caused by the unequal distension of the sac by its contained fluid. (See Fig. 131.) The central canal of the spinal cord has been seen to open at the bottom of the umbilicus. Occasionally, the sac is divided into

FIG. 131.

Spina Bifida, showing the umbilicus, or central depression, where the spinal cord is adherent to the sac-wall.

partitions by septa, and these also may produce depressions or grooves.

The **coverings of the sac** are rarely normal skin and subcutaneous tissue. In most cases the base alone is covered by skin, which gradually thins away towards the fundus, so that the summit of the latter is either covered by a thin layer of epidermis or by a glistening membrane composed of the spinal membranes or of the thinned and adherent cord.

Syringo-myelocele is a rare form of spina bifida in which the central canal of the cord is immensely *distended* and forms the sac-cavity, the sac-wall being *lined* by the expanded spinal cord itself. At first

such a spina bifida might easily be mistaken for
ıple meningocele, for no nerves traverse the sac-
y. Close examination, however, shows that the
es are contained in the substance of the sac-wall,
ȝ given off from the distended cord.
ıe coverings of a syringo-myelocele are of the same
re as those of a meningo-myelocele.
ıe congenital deficiency which results in the for-
on of any spina bifida consists in an imperfect
lopment of the mesoblast on each side of the
ɔbral furrow from which the spinal meninges
the vertebral laminæ are normally produced.
mesoblast being deficient, these structures remain
ɔveloped in varying degrees.
ıe complications of spina bifida which are com-
are hydrocephalus, talipes, and paralysis of the
ım and bladder.
ıe termination of the majority of cases of spina
a is death. This commonly results from the sac
ıg way, an event which is followed by myelitis or
ulsions. Other children die in a marasmic condi-
without any very definite lesions being present.
small proportion of the meningo-myeloceles, and
considerable number of the simple meningoceles,
sac gradually shrinks and a natural cure is
ted.

CHAPTER LXIV.

TALIPES—CLUB-FOOT.

TALIPES, or club-foot, may be either congenital or acquired, may affect one or both feet, and is equally common in male and female children.

CAUSES.

The **congenital** form is attributed by different authors to three different causes—(1) spasmodic contraction or paralysis of muscles, resulting from nerve-irritation or loss of function; (2) malformation of the tarsal bones; (3) mechanical pressure by the uterus, or by malposition of the fœtus.

The theory that the deformity is due to some affection of the nervous centres is supported, first, by the undoubted fact that after birth talipes certainly results in many cases from disease of the spinal cord, and, second, by the very frequent association of malformations of the cord and brain such as are seen in spina bifida and anencephalus.

In the absence of any demonstrations of primary disease of the spinal cord in the fœtus, the proof that myelitis produces congenital talipes must be declared wanting, although there is much to be said in its favour from a theoretical point of view. The frequent association with spina bifida and anencephalus is, however, a fact which renders it highly probable *that* their co-existence is more than a coincidence, and *that,* in these cases at any rate, the deformity of the

the direct result of the lesion of the cord which
monly present.
second theory, which explains the deformity by
ect development of the tarsal bones, is probably
ous, the changes found in the latter being the
and not the cause, of the talipes.
third theory, that the club-foot is the result of
nical pressure by the uterus or by adventitious
or of malposition of the fœtus, finds its
st support in a paper by Messrs. Parker and
ck,* and may be summed up in their own
:—"Our argument is that the feet of the fœtus
various positions during the course of intra-
e life, and that this occurs in order that the
urfaces, the muscles, and especially the liga-
be developed so as to allow of that variety of
ns and movements which are afterwards to be
l to the foot; and we hold that when anything
anically) prevents the feet from assuming these
ns at the proper time, or maintains them in
ven position beyond the limit of time during
they should occupy such position, a talipes
. The variety of talipes will depend on the
f its production; its severity will be in direct
to the mechanical violence at work. If the
on of the foot, which is normal during the
months of fœtal life, be maintained beyond
rmal period of time, the muscles and ligaments
s a consequence be adaptively short on one
of the limb, and too long on the other—a
l position of inversion will finally become a
ity. Talipes calcaneus is, we believe, pro-
in a similar manner; it occurs, however, later
intra-uterine life, when a flexed position of
ot is normal. Being thus less fundamental in
ter, as a deformity it is also less severe than

*nsactions of the Pathological Society," vol. xxxv. p. 423.

In support of this explanation the authors adduce various examples of fœtal malposition and pressure which seem quite sufficient to prove that the theories they advocate are supported by facts, and to establish such mechanical conditions as one of the causes of congenital club-foot, and probably the one which is most frequently operative.

Acquired talipes commonly results from disease of the spinal cord. This in some cases is irritative in its nature and produces spasm of certain muscles, which, at first by their vital contraction, and afterwards by their tendency to become permanently shortened, cause an active displacement of the foot; *e.g.*, spasm of the calf muscles will result in a drawing up of the heel, or "talipes equinus."

In another class of cases the lesion of the cord is of a destructive nature, the large nerve-cells in the anterior cornua being destroyed. This lesion, which is known as "anterior polio-myelitis," results in the condition called "infantile paralysis." The motor cells, which are the centres of nutrition for the motor nerves and the muscles they supply, being destroyed, the nervous and muscular fibres degenerate and atrophy, and deformities are produced both by shrinking of the paralysed muscles as well as in other cases by their stretching. Thus, if all the muscles of the leg are paralysed, the foot usually hangs in a helpless condition, with the toes pointed and somewhat inverted, and in this position, that of "talipes equino-varus," it may be permanently fixed in the course of months by the atrophy and shrinking of the calf-muscles. In other cases, where the calf-muscles are alone or chiefly affected, the extensors will support the foot, and the pressure on the sole in walking will tend to stretch the wasted soleus and gastrocnemius until the heel is permanently depressed and "talipes calcaneus" is produced. In some cases of polio-myelitis the paralysis passes off, but unless this improvement occurs within the first month or two

after the attack there is little probability of recovery; the muscles then rapidly waste, the skin becomes blue and cold, and, unless precautionary measures are taken, deformities such as have been described will be developed. In advanced cases the muscles consist of little else than fat.

In a few cases talipes is caused by contraction of scars about the ankle-joint, and, as will be explained in the sections on flat-foot and valgus, it is also the result of muscular weakness and yielding of ligaments. Again, when one limb is shorter than the other—*e.g.*, as the result of hip disease—the constant walking on the toes may produce permanent talipes equinus.

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FIG. 132.

Dissection of a Foot with Talipes Equino-varus.

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them backwards on to the heads of the metacarpal bones.

In cases of equinus, again, the dislocation backwards of the first phalanges is produced by the efforts of the common extensor (together with other muscles) to maintain the foot in its natural position. Further, as regards the cavus, when the patient constantly walks on his toes, there is not only a tendency for the latter to be displaced by the weight they support, but the arch of the sole is increased by the contraction of those muscles whose tendons pass across it, especially the tibialis posticus and the peroneus longus. In all cases of long standing, the plantar fascia is thickened and contracted, and offers material resistance to attempts at replacement.

TALIPES PLANUS.

Talipes planus, or flat-foot, is an acquired deformity, and results from muscular overwork and consequent weakness and loss of tone. The arch of the foot does not exist in an infant, and is only developed when the child begins to walk, being, in fact, produced by the contractions of the muscles whose tendons pass across the sole. The arch thus formed is also maintained by the use of the muscles, and the weight of the body does not rest, or depend for its support, directly upon the ligaments. If, therefore, the muscles, from overwork, lose tone and become weak and flabby, the weight of the body is no longer maintained by their healthy contraction, the foot is not braced by their support, and the ligaments, now called upon to do more than they were originally intended for, yield and stretch beneath their burden.

All the ligaments of the sole may be more or less implicated, but those which are most notably stretched are the inferior calcaneo-scaphoid and the long plantar. The head of the astragalus, being no longer supported, sinks down on to the soft structures forming the sole, and the bone, at the same time sliding forwards,

pushes the scaphoid in front of it, and causes a displacement of the anterior half of the tarsus to the outer side. In the early stage of flat-foot, the head of the astragalus can be replaced, and the arch temporarily restored by artificial pressure; but in cases of longer standing this is not possible, and the whole foot becomes rigid and stiff. The pressure of the displaced astragalus also gives rise to much aching pain, which is increased by walking. The deformity is most common in growing boys and girls about the age of puberty who are employed in some occupation which necessitates prolonged standing.

Another cause of flat-foot deserves mention, although briefly. It is liable to supervene in patients who suffer from chronic rheumatism, and it sometimes occurs in those who suffer from so-called gonorrhœal rheumatism.

TALIPES VALGUS.

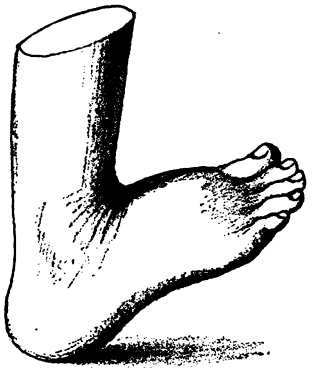
Talipes valgus consists of a displacement outwards of the tarsus at the mid-tarsal and sub-astragaloid joints, and is practically an exaggerated condition of talipes planus. It may develop out of an ordinary flat-foot, or result from infantile paralysis of the muscles of the calf and inner side of the leg in patients in whom the peronei and extensors escape. In such cases it is sometimes complicated by calcaneus. In talipes valgus the arch is flattened, the foot is everted, the cuboid bone is approximated to the external malleolus, and the head of the astragalus forms a projection on the inner side. The peronei muscles are contracted, and resist efforts at replacement of the foot.

TALIPES CALCANEUS.

Talipes calcaneus is a rare form of club-foot. In it the heel is depressed and the toes are drawn up towards the shin. It is in some cases congenital, but in others results, as already explained, from the stretch-

ing of the atrophied calf-muscles in cases where the latter are affected by infantile paralysis. The chief anatomical abnormality is undue length of the tendo-

FIG. 133.



A Foot with Talipes Calcaneus.

Achillis or of the muscles inserted into it, with consequent inability to stand on the toes or to propel the body forwards in the act of walking. It is combined in some cases with valgus.

CHAPTER LXV.

GENU VALGUM.

GENU VALGUM, or knock-knee, is an outward displacement of the tibia on the femur, with consequent separation of the internal malleoli and the feet, and a tendency for the knees to rub against one another in the act of walking.

Causes.—Unlike most other deformities, genu valgum is never congenital. It is developed in young children in consequence of rickets, or else at puberty —and seldom later—from muscular weakness and overwork.

In rickety children the femur tends to become bent in an outward and forward curve in the upper and middle parts of its shaft, with the result that there is developed, first, a tendency for the axes of the legs to cross, and, secondly, a compensating curve of the lower third of the bone, with the convexity inwards. But although this secondary curve is, in a limited degree, of use, nevertheless, by directing the lower articular surface of the femur outwards, it causes the knee-joint to be placed obliquely instead of transversely across the long axis of the lower extremity, so that the weight of the body is transmitted down a line which falls through the outer condyle to the inner side of the foot. If the rachitic and softened state of the bones continues, the curve tends to increase, and the tibia is directed further and further away from the middle line, whilst, in addition, the knee-joint

being no longer placed transversely to the axis of the limb, the internal lateral ligament is placed at a disadvantage, stretches, and allows the tibia to be displaced from its articulation with the femur.

In adults, knock-knee is primarily due to muscular weakness, the knee-joint, like the sole of the foot, depending for its integrity, not only on ligaments, but also on muscles. If, therefore, from overwork in young and growing patients, the muscles lose tone, the ligaments are soon unable to maintain the articular surfaces in their normal position, and genu valgum results. The reasons why the tibia is displaced outwards, and the internal lateral ligament yields rather than the external, are that, the foot and leg being normally slightly rotated outwards, the strain is naturally thrown on the inner side, and that the fascia on the outer side of the joint is much stronger and denser than that on the inner, and therefore less likely to yield and stretch.

From whatever cause arising, the deformity tends to increase. The whole weight of the body is now placed on the external condyle and outer articular surface of the tibia, the internal condyle and inner articular surface being separated slightly from one another. As a consequence, the growth of the external condyle is arrested by the constant pressure, whilst that of the internal continues, and the necessary result is a relative elongation of the internal condyle, which then acts as a mechanical obstruction to all attempts at replacement of the displaced tibia. The soft tissues, also, on the outer aspect of the limb accommodate themselves to the altered position of the parts, and in time become contracted and shortened to such an extent as to resist all attempts at forcible straightening; the structures in such cases which are most unyielding are the fascia lata, the biceps, and the external lateral ligament.

In **genu varum** the knee is bowed outwards instead of inwards, so that, whilst the feet tend to knock against one another, there is a considerable space between the knees. Genu varum commonly results from rickets, and is much more rare than genu valgum.

CHAPTER LXVI.

CONGENITAL DISLOCATION OF THE HIP.

CONGENITAL dislocation of the hip is met with much more frequently in female than in male children, and may occur on one or both sides. It occasionally

FIG. 134.

Congenital Displacement of the Right Femur, showing the head of the bone included within the capsular ligament. (From the museum of St. Thomas's Hospital.)

affects several members of the same family, and may be hereditary.

The head of the femur is displaced upwards and backwards, and the shaft is rotated inwards. The capsule is exceedingly loose, and allows of very considerable movement of the femur on the ilium. The head

FIG. 135.

Congenital Displacement of the Femur, showing the triangular acetabulum, the roughened spot where the head of the bone has rested, and the flattened femoral head. (From the museum of St. Thomas's Hospital.)

of the femur is always more or less flattened by pressure, and in some few cases has been found undeveloped from birth. The dorsum ilii is flattened or slightly hollowed by the constant pressure of the femoral head. The gluteal muscles are usually fatty and ill-developed, on account of the little use to which they are put in the altered position of the parts.

The condition of the acetabulum is, however, the

most important feature, for in all the specimens in the museums of London it is very imperfectly developed. The developmental deficiency is also remarkably uniform, and consists in a suppression of that part of the cavity which is formed by the ilium—of what may be called the iliac segment. The acetabulum, in consequence, is formed by the pubes and ischium alone, and, instead of being round, is of a triangular shape, with the apex upwards. It is, in addition, very shallow, with margins scarcely raised above the level of the surrounding bone.

It is now tolerably certain that the failure of development of the acetabulum is the real cause of the displacement of the femur, and there is little doubt that the theory which has been accepted until the present time, that the dislocation is a traumatic one produced by the accoucheur during delivery, is erroneous. In most cases there is no history of any difficulty at birth; whilst the facts that the displacement is occasionally hereditary, that it affects chiefly female children, that it is often double, that the head of the bone is always within its capsule, and that no case has yet been described in which any laceration of the tissues has been found, render it highly improbable that difficulties during parturition have anything to do with the causation of the deformity.

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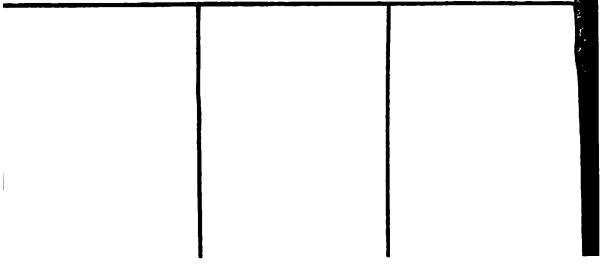

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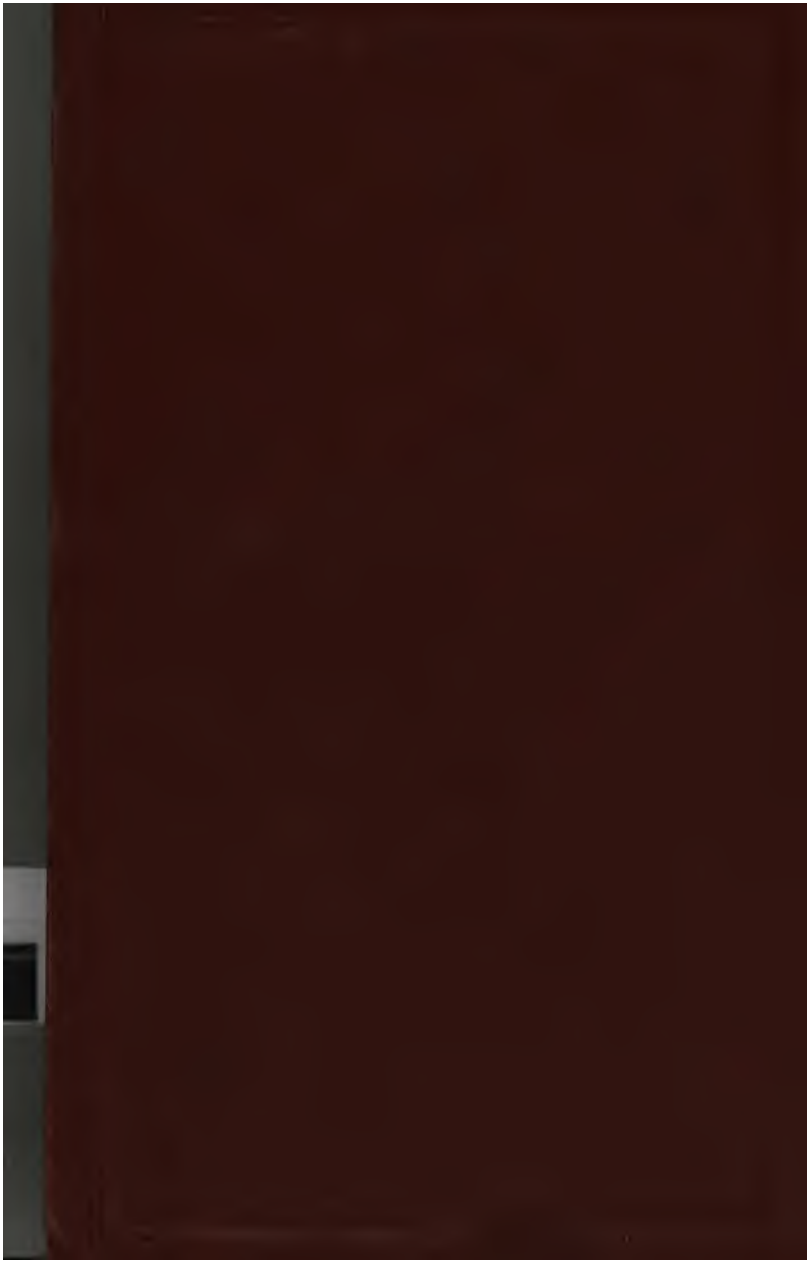
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